Mental health nursing and its practice with Aboriginal and Torres Strait Islander peoples in public mental health services: A multi-sited ethnography.

By

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Ar scáth a chéile a mhaireann na daoine.

Statement of Original Authorship

This thesis contains no material which has been accepted for a degree or diploma by the University of Tasmania or any other institution, except by way of background information and duly acknowledged in the thesis, and to the best of my knowledge and belief no material previously published or written by another person except where due acknowledgement is made

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The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, as approved by the Human Research Ethics Committee (Tasmanian Network) (H0014330), St. Vincent's HREC (LNR/15/SVH/408) and Far North Queensland HREC (HREC/15/QCH/40-971).

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Statement of Co-authorship

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Paper 3, Nursing care and Indigenous Australians: An autoethnography.

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Paper 4, More satisfying than factory work: An analysis of mental health nursing using a print media archive.

Located in Chapter Six: Candidate was the primary author and contributed 75% to the planning execution and preparation of the research project and subsequent paper. Authors 1 and 2 contributed to the analysis and interpretation of the research data and contributed to the interpretation of the work by critically revising the paper.

Paper 5, Lip service: public mental health services and the care of Aboriginal and Torres Strait Islander peoples.

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Paper 7, Encounters with difference: Mental health nurses and Indigenous Australian users of mental health services.

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Glossary of key terms

Aboriginal and Torres Strait Islander People.	Aboriginal and Torres Strait Islander peoples are the first inhabitants of Australia. Aboriginal peoples are diverse Aboriginal nations that have historically lived on the mainland of Australia and in many of the country's offshore islands. While Torres Strait Islander peoples come from the islands of the Torres Strait, between the north of Australia and Papua New Guinea. Torres Strait Islanders are of Melanesian origin.
Australian College of Mental Health Nurses	The Australian College of Mental Health Nurses (ACMHN) is the peak professional mental health nursing organisation and the recognised credentialing body for mental health nurses in Australia.
The Other	The Other is a person or group of people who are different from the social identity of a person (Miller, 2008).
Mental Health Nurse	According to the Australian College of Mental Health Nurses (2010, p.5), a mental health nurse is 'a registered nurse who holds a recognised specialist qualification in mental health. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual'. According to this definition, many nurses who work within mental health services are not mental health nurses either through lack of post registration qualifications, or through their constrained scope of practice or employed role. For the purposes of this project which is interested in the culture of mental health nursing this definition will include that community of registered nurses who identify as mental health nurses and/or are employed by mental health services.
Mental Health Nursing	According to the Australian College of Mental Health Nurses (2018), mental health nursing is a specialist practice focused on working with people who have mental health

	issues, to meet their recovery goals. The practice considers the person's physical, psychological, social and spiritual needs, within the context of the individual's lived experience and in partnership with their family, significant others and the broader community.
Public Mental Health Service	A publicly funded organisation operating at a community level to aid in the prevention and treatment of mental disorders. They provide specialised mental health care delivered in public acute and psychiatric hospital settings; state and territory specialised community mental health care services, and state and territory specialised residential mental health care services (AIHW, 2018).
Biomedical paradigm	A model of health and illness that exclusively focuses on biological factors, excluding psychological, environmental, and social influences. In the context of mental health, the model posits that mental illness is a consequence of brain disease and emphasises pharmacological treatment to target presumed biological abnormalities (Deacon, 2013).
Discourse	'Systems of thoughts composed of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak' (Lessa, 2005, p. 285)
Alterity	The quality or state of being radically alien to the conscious self or a particular cultural orientation (Merriam Webster, 2018)
Positionality	Maher and Tetreault (1994, p. 22) define positionality as the 'knower's specific position in any context as defined by [ethnicity], gender, class, and other socially significant dimensions'.
Comprehensive nursing	Comprehensive nurse education was first introduced in Australia in 1984 and aimed to produce a graduate nurse with a wide range of clinical skills and knowledge relevant to

	many clinical settings. Specialisation was to occur at a postgraduate level.
Cultural safety	Cultural safety has been defined as "The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability" (Nursing Council of New Zealand, 2011, p. 7).
Cultural security	Cultural security is a commitment by health services to the principle that the construct and provision of services will not compromise the cultural rights, values and expectations of Aboriginal and Torres Strait Islander people (Northern Territory Department of Health, 2016).
Cultural sensitivity	A state of attunement with, and meaningful responsiveness to, the needs and feelings of people from diverse cultural backgrounds (Laszloffy & Habekost, 2010).

Abstract

Since the 1990s, significant problems with the public mental health services provided to Aboriginal and Torres Strait Islander peoples have been identified. Mental health professionals have been found to have had little understanding of Aboriginal and Torres Strait Islander culture, and this has often resulted in inappropriate treatment and care.

The purpose of this multi-sited ethnography was to undertake an ethnographic analysis of the culture of mental health nursing in relation to its practice with Aboriginal and Torres Strait Islander users of public mental health services. Data collection, conducted between February 2014 and October 2016, involved interviews, observational fieldwork and document analysis. Observational fieldwork included participant observation at two Australia College of Mental Health Nurses conferences and nonparticipant observation in two public mental health services: (i) a regional mental health service; and (ii) an inner city mental health service. In-depth interviews were conducted with seventeen mental health nurses from across the country. Document analysis was undertaken of relevant documents, including historical documents related to the speciality.

Mental health nurses practising in public mental health services described how the ideology of biomedical psychiatry dominated treatment and care. This dominance constricted mental health nursing practices to those that complemented biomedical interventions, stifling the development of culturally appropriate care for Aboriginal and Torres Strait Islander service users. While local and national attempts to improve mental health services for Aboriginal and Torres Strait Islander peoples focused on raising individual cultural awareness, the institutional culture in services was dominated by interventions which ignored culture and its implications for care and treatment.

The research found that many mental health nurses were unclear about what form specialist practice would take in addressing social and emotional wellbeing for Aboriginal and Torres

Strait Islander service users. The speciality of mental health nursing had not developed a clear knowledge base to support practice and the approaches to nursing care were disunited. Practice was constructed from individual nurse's belief and ideas and shaped by their experience of working in mental health services.

Mental health nurses positioned the Aboriginal and Torres Strait Islander service user as *Other* both to themselves, and to non-Indigenous service users. Cultural difference and the legacy of colonisation, including its impact on the health of Aboriginal and Torres Strait Islander peoples, contributed to these beliefs of alterity. Despite an emphasis on difference, mental health nurses did not relate this to Indigenous ways of understanding ill-health using the concept of social and emotional wellbeing. While cultural differences were recognised, what they meant for the nurses or their nursing practice was interpreted in diverse ways. In these circumstances, approaches towards care for Aboriginal and Torres Strait Islander peoples varied considerably between mental health nurses.

Chapter One. Introduction

1.1 Study context

Aboriginal and Torres Strait Islander peoples are the first inhabitants of Australia. Aboriginal nations have historically lived on the mainland of Australia and in many of the country's offshore islands. Torres Strait Islander peoples come from the islands of the Torres Strait. These islands are situated between the north of Australia and Papua New Guinea. According to the 2016 census, Aboriginal and Torres Strait Islander peoples represent 2.8 percent of the population of Australia, with 91 percent being of Aboriginal origin, 5 percent being of Torres Strait Islander origin, and 4.1 percent reporting being of both Aboriginal and Torres Strait Islander origin (Australian Bureau of Statistics, 2017a).

To understand the contemporary experiences of Aboriginal and Torres Strait Islander peoples, historical background is essential (Dudgeon, 2014). Archaeologists have identified that people lived in Australia for at least 50,000 years prior to the beginning of colonisation in 1788 (Broome, 2002). During colonisation, Aboriginal and Torres Strait Islander peoples were subjected to an unremitting invasion and were victims of poisoning, shootings and rape, as settlers spread across their lands (Eckermann et al., 2010; Reynolds, 2013). Furthermore, the introduction of diseases, including smallpox, measles, and influenza, led to the massive depopulation of Indigenous communities (Broome, 2002). The takeover of land by settlers excluded communities from their traditional food sources, which led to widespread hunger and associated illnesses (Eckermann et al., 2010). Later, colonialist policies led to the relegation of Aboriginal and Torres Strait Islander peoples into government reserves and Christian missions, separation, death, and the erosion of cultural traditions (Eckermann et al., 2010). The

catastrophic consequences of colonisation continue to affect Aboriginal and Torres Strait Islander Australians to the present day (Dudgeon, 2014; Australian Health Ministers' Advisory Council, 2017).

An overview of Indigenous health status can provide an insight into how colonisation continues to affect Aboriginal and Torres Strait Islander communities. These statistics should be viewed in the context of the tremendous strength and resilience that have been characteristic of Aboriginal and Torres Strait Islander communities in the face of extreme adversities (McNamara et al., 2018). Currently, it is estimated that an Aboriginal and Torres Strait Islander person born between 2010-2012 is likely to live about ten years less than a non-Indigenous person born during the same period (Australian Bureau of Statistics, 2013). Some examples of Indigenous health disparities include long-term cardiac conditions which are around 1.2 times more common for Aboriginal and Torres Strait Islander people than for non-Indigenous people; cancer rates are 1.3 times higher; diabetes rates are 3 times higher; renal disease rates are 6.6 times higher, and the level of respiratory disease is 1.2 times higher (Australian Indigenous HealthInfoNet, 2017). There are also significant disparities seen in communicable diseases including pneumonia, tuberculous, sexually transmissible infections and hepatitis (A, B and C) (Quinn, Massey, & Speare, 2015). The overall rate of disability rate for Aboriginal and Torres Strait Islander people is 1.7 times the rate for non-Indigenous people (Australian Indigenous HealthInfoNet, 2017).

Colonisation traumatically impacted on Aboriginal and Torres Strait Islander communities with resulting intergenerational mental health impacts (Calma, Dudgeon, & Bray, 2017). Aboriginal and Torres Strait Islander people have reported experiencing psychological distress at a rate three times that of non-Indigenous people (Matthews, Bailie, Laycock, Nagel, & Bailie, 2016). Mental disorders are reported to be the leading cause of disease burden among Aboriginal and Torres Strait Islander peoples after cardiovascular disorders (Australian

Institute of Health and Welfare, 2016). According to the 2014-15 National Aboriginal and Torres Strait Islander Social Survey, 29 percent of Aboriginal and Torres Strait Islander people (n=11,178) reported having a diagnosed mental health condition (25 percent of males and 34 percent of females) (Australian Bureau of Statistics, 2016). Aboriginal and Torres Strait Islander people living in non-remote areas were twice as likely to report a diagnosed mental health condition than those living in remote areas (33 percent compared with 16 percent) (Australian Bureau of Statistics, 2016). The Australian Bureau of Statistics has estimated that 20% of the broader Australian population experience a diagnosed mental condition in any year (Australian Bureau of Statistics, 2008).

In the context of public mental health service provision, specialised community mental health service contacts for Aboriginal and Torres Strait Islander peoples were four times the rate for non-Indigenous Australians in 2014–2015 (Australian Health Ministers' Advisory Council, 2017). Between 2011 and 2013, the hospitalisation rate for Indigenous women with mental health issues was 1.5 times the rate for non-Indigenous women, and the hospitalisation rate for Indigenous men with mental health issues was 2.1 times the rate for non-Indigenous men (Australian Health Ministers' Advisory Council, 2017). Between 2013 and 2015, 5 percent of all emergency department presentations for Aboriginal and Torres Strait Islander people were mental health related, compared to 3 percent for non-Indigenous presentations (Australian Institute of Health and Welfare, 2016b). Once admitted to hospitals, the average length of stay for Indigenous inpatients was ten days, compared to twelve days for non-Indigenous inpatients (Australian Health Ministers' Advisory Council, 2017). The State of Victoria has provided information on the most prevalent disorders for Aboriginal and Torres Strait Islander people using its public mental health service (Department of Health and Human Services, 2014). These were identified as schizophrenia and delusional disorders (21 percent); mood disorders (19 percent);

stress-related disorders (18 percent), followed by substance abuse related disorders (8 percent) (Department of Health and Human Services, 2014).

Suicide is believed to have been a rare occurrence among the Aboriginal and Torres Strait Islander people in pre-colonial times. However, it has become increasingly prevalent in communities since the 1980s (Australian Bureau of Statistics, 2012). In 2016, deaths from suicide accounted for a greater proportion of all Aboriginal and Torres Strait Islander deaths (5.5 percent) compared with deaths by suicide for non-Indigenous Australians (1.7 percent) (Australian Bureau of Statistic, 2017b). The median age for Aboriginal and Torres Strait Islander persons dying by suicide was 29, compared with 45 for non-Indigenous persons (Australian Bureau of Statistics, 2017b). Aboriginal and Torres Strait Islander people under 18 years of age accounted for approximately 30 percent of suicide deaths in that age group between 2007–2011, despite only representing 5.5 percent of the national population for the age group (Dudgeon & Holland, 2018).

Substance use, including illicit drug use and alcohol use, are associated with negative impacts on health and social harms that have been reported to disproportionately affect Aboriginal and Torres Strait Islander communities (MacRae & Hoareau, 2016; Gray et al., 2017). Aboriginal and Torres Strait Islander peoples are more likely to experience exposure to child neglect and abuse, violence, and contact with the criminal justice system than non-Indigenous Australians (MacRae & Horeau, 2016; Gray et al., 2017; Australian Health Ministers' Advisory Council, 2017). Drug-related hospitalisations for mental/behavioural disorders for Aboriginal and Torres Strait Islander peoples was three times higher than the rate for non-Indigenous people (Steering Committee for the Review of Government Service Provision, 2014). Mental and behavioural disorders due to psychoactive substance use, including alcohol, represents approximately one-third of all mental health-related hospitalisations among Aboriginal and Torres Strait Islander women and 43.4 percent among Aboriginal and Torres Strait Islander

men (Gray et al., 2017). High levels of alcohol and drug use have been noted in Indigenous suicide clusters (Dudgeon, Calma, & Holland, 2017).

Aboriginal and Torres Strait Islander people living in urban areas are generally less disadvantaged than those people living in rural and remote areas as they typically have improved employment, education and health outcomes (Brand, Bond, & Shannon, 2016). However, within urban environments, substantial variations have been found. For example, the Indigenous population in urban areas such as Blacktown and Campbelltown in Sydney have social and economic issues that were closer to those found in remote Australia (Biddle, 2013). Hospitalisation rates are lower Aboriginal and Torres Strait Islander people in remote areas for mental and behavioural disorders, compared with Aboriginal and Torres Strait Islander people living in major cities (Australian Institute of Health and Welfare, 2014). Geographical factors such as long distances restrict access to services (Australian Institute of Health and Welfare, 2014).

1.2 Aboriginal and Torres Strait Islander social and emotional wellbeing

For Aboriginal and Torres Strait Islander peoples, social and emotional wellbeing is the foundation for both physical and mental health (Commonwealth of Australia, 2017). This conceptualisation of health recognises the importance of connection to family, community, culture, land, spirituality and ancestry, and how these affect the individual (Gee et al., 2014). Swan and Raphael (1995, p. 19) have noted this:

> ‘Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. This holistic concept does not just refer to the whole body but is in fact steeped in harmonised interrelations which

> constitute cultural wellbeing. These interrelating factors can be categorised largely into spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist'.

Aboriginal and Torres Strait Islander understandings of social and emotional wellbeing is found to vary between communities and individuals (Gee et al., 2014).

Hellsten (2015) notes that mental illness and social and emotional distress differ, with the latter resulting from the socio-political disadvantages experienced by Aboriginal and Torres Strait Islander peoples since the beginning of colonisation. This distress is unlikely to be relieved by psychiatric interventions (Westerman, 2004; Hellesten, 2015). It is increasingly recognised that to improve social and emotional wellbeing in Indigenous communities, there needs a focus on increasing community capacity and community resilience (Parker & Milroy, 2014). Cultural healers also play a key role in maintaining social and emotional wellbeing and healing social and emotional distress in individuals (Commonwealth of Australia, 2017). Optimal health service provision should combine traditional healing-based treatments informed by the person's culture, with clinical approaches focused on holistic wellbeing (Commonwealth of Australia, 2017).

1.3 Positioning myself within the context of this research

I emigrated from Ireland to Australia in 2004. I had qualified for a skilled migration visa due to my professional background as a registered psychiatric nurse and was sponsored to work in an acute inpatient ward in the inner city of Sydney. I had left Ireland hoping for some adventure living overseas and had planned to be back in four years. I was qualified nearly five years at

that point and had left with confidence in my practice as a psychiatric nurse. After a few weeks of working out the local routines and processes, I felt comfortable in my role. I remember telling my dad that the only real difference between the inpatient unit I was working in now, and the one I had worked at in Ireland, was the accents.

There was a point when I was caring for my first Aboriginal service user when I thought to myself, 'I don't know what I am doing'. One afternoon while the morning shift was handing over care to the afternoon shift, a nurse wondered if it was 'an Aboriginal thing' when I pointed that there was no change in the person's mental state despite her having spent several weeks on the inpatient unit. The comment confused me. What was 'an Aboriginal thing'? What did it mean for me as a nurse who regularly had this person allocated to me for her nursing care? Why did I not know about 'Aboriginal thing[s]'? And what did I need to know about them in relation to my nursing care?

Before I came to Australia, my understanding of Aboriginal and Torres Strait Islander peoples was impersonal and limited. My knowledge was based on the history I had learnt in school about the settlement of Australia. Aboriginal people seemed to me to be there initially to observe the arrival of the British but then disappeared from the pictures that followed. I had vague memories about the film 'Crocodile Dundee' having Aboriginal and Torres Strait Islander characters who lived in the desert. I had watched Aboriginal and Torres Strait Islander people play digeridoo at Sydney's ferry terminus a few times. That was about it. After nearly two years of living in Australia, I had not gained any greater understanding of the first Australians or their history, or their culture, than when I first set foot in the country.

I looked in the direction of my Australian colleagues, who I would label 'caring' and who seemed to have a good knowledge about acute care for mental health inpatients. We tried to nurture helping relationships, we gave out medications, we observed behaviour, and we reported back to 'treating teams' of psychiatrists who guided interventions with 'treatment'

plans. There was nothing different in the approach taken with people who were admitted to the ward. This was the same for Indigenous and non-Indigenous people.

When I started to read about Aboriginal mental health to see if I could get an understanding of the nurse's comment, I found literature that made me uncomfortable. I read about an Indigenous concept that went beyond my understanding of mental health, encompassing community, spirituality and ancestry (Swan & Raphael, 1995). I read about national reports criticising mental health services and the health professionals working in them going back over twenty years (Human Rights and Equal Opportunity Commission, 1993). I read about the Indigenous experience of invasion and colonisation (Broome, 2002; Kidd, 2005). The readings made me think of my care, of my profession's practice and of the services in which we worked.

I position myself as a 'biographically situated researcher' whose influences pervade this ethnography from start to finish (Denzin & Lincoln, 2011, p 12). I come from a country that was colonised and growing up I did not experience ambiguity about the horrific impact that colonisation had on the Irish people. I had a clear sense of what this history was to me and a strong sense of its continuing impact on our island and its peoples. In coming to Australia, I have been acutely aware that I have transitioned to becoming a person who is now a beneficiary of a history of settler colonialism. I have encounter ambiguity about the history of colonisation. I have seen it celebrated. This ethnography has been influenced by my own attempts to understand the non-Indigenous culture I now find myself within.

1.4 Public mental health services and Aboriginal and Torres Strait Islander peoples

Since the 1990s, significant problems with the public mental health services provided to Aboriginal and Torres Strait Islander peoples have been identified (Royal Commission into

Aboriginal Deaths in Custody,1991; Human Rights and Equal Opportunity Commission, 1993; Swan & Raphael, 1995). Both the Royal Commission report and the Burdekin report found that mental health professionals had little understanding of Aboriginal and Torres Strait Islander culture and this often resulted in inappropriate treatment. These reports outlined how the denial of human rights within a discriminatory mental health system placed a serious burden on Aboriginal and Torres Strait Islander people (Mental Health Commission of New South Wales, 2013; Calma et al., 2017). Despite these reports and later attempts at change through the National Strategic Framework (Commonwealth of Australia, 2004) and the National Mental Health Plan (Commonwealth of Australia, 2009), health professionals have continued to work in exclusionary ways to the detriment and disadvantage of Indigenous service users (Walker & Sonn, 2010; Trueman, 2017; McGough, Wynaden, & Wright, 2018). Inflexible models of service delivery and inadequate cultural awareness have continued to present barriers for Indigenous Australian service users (Isaacs, Pyett, Oakley-Browne, Gruis, & Waples-Crowe, 2010; Walker, Schultz, & Sonn, 2014; McGough et al., 2018). The mental health needs of Aboriginal and Torres Strait Islander people continue to be marginalised by the mental health system (Calma et al., 2017).

Since the publication of Ways Forward, the Australian Government's national Aboriginal and Torres Strait Islander mental health policy report in 1995, health policy and planning have increasingly recognised that mental health and well-being are intrinsically connected to the 'whole of life' for most Aboriginal and Torres Strait Islander peoples (Swan & Raphael, 1995, p. 20). After the publication of Ways Forward, policy related to mental health has focused on Aboriginal and Torres Strait Islander social and emotional wellbeing. Such policy recognises that factors pertaining to Aboriginal and Torres Strait Islander peoples' social and emotional wellbeing extend beyond the mental health system to encompass education, law and justice, human rights and Native Title (Zubrick, Kelly & Walker, 2014). Social and emotional

wellbeing has been described being 'a deep-rooted more collective and holistic concept of health and mental health than Western concepts' (Calma et al., 2017, p 256). The concept of mental illness as a physiological disease within the biomedical paradigm, therefore, fails to address Aboriginal and Torres Strait Islander health perspectives (Saggers & Grey, 2007, Dudgeon 2014). Furthermore, this paradigm is based on an approach to illness and disease that is both inappropriate and irrelevant to the beliefs of most Aboriginal and Torres Strait Islander peoples (Westerman, 2004).

1.5 Towards an ethnography of mental health nursing practice

When I read about criticisms of the services, I imagined there would be a written resource related to mental health nursing and Aboriginal and Torres Strait Islander peoples that could guide my practice. Something that would perhaps describe mental health nursing practice in relation to the concept of social and emotional wellbeing. However, I could not find such guide. To understand this area of practice, I believed I needed to research mental health nursing. I wanted to undertake an inquiry into the circumstances of mental health nursing in public mental health services in Australia and its specialist practice with Aboriginal and Torres Strait Islander peoples. Those ideas ultimately ended up bringing me to this research.

One of the first issues I found myself facing in thinking about research focused on mental health nursing in Australia was: what constituted mental health nursing in Australia? Coming from Ireland, I was used to a bounded specialist group, specifically trained in mental health nursing and identified by a stand-alone registration. In my service experience in Australia, there were specialist trained nurses who had trained overseas or before the introduction of the 'comprehensive' model of nurse training. However, the majority had come through 'comprehensive' training, which provided an introduction to mental health and nursing in a

broader nursing curriculum but relegated specialist mental health nurse training to the post 'basic' nursing education.

Within this group in the ward setting where I worked, there was more staff who had not done post-graduate training, than those who had. From my experience, this disparity of staff expertise and training was replicated in other services in which I had worked in Sydney and Western Australia. Paradoxically, it seemed that following nursing's movement into the university system, for many nurses working in mental health, there was a return to hospital-based training to develop their specialist mental health nursing practice. The situation left public mental health services staffed by specialist-trained mental health nurses and registered nurses who worked in mental health.

The Australian College of Mental Health Nurses (2010, p 5) identifies a mental health nurse in the Australia context as being 'a registered nurse who holds a recognised specialist qualification in mental health. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual'. However, when I thought about researching mental health nursing in public mental health services in Australia, I believed that a study should focus on all registered nurses who worked in mental health services providing nursing care.

1.6 Mental health nursing in Australia.

The analysis and interpretation of mental health nursing history provides context for evaluating contemporary institutions and professional culture (Leishman, 2005, p 1158). This history differs from the other branches of nursing in Australia (Evans, 2013). However, it has mirrored developments in other English-speaking countries such as the United Kingdom and Canada.

Similarly to these countries, Australia developed asylums as an approach to keeping people experiencing mental illness in supervised, often long-term, custody (Kirkby, 1999). The first opened in Australia at Castle Hill in 1818; with others following in all the other colonies (Evans, 2013). These asylums followed the British model of treatment and were reflective of the views of medical superintendents who migrated to the colonies to oversee them (Happell, Cowin, Roper, Foster, & McMaster, 2008).

Attendants were the most numerous workforce in these institutions and were in a position to exercise considerable power over the patients (Smith, 1988). By 1915 the term 'mental hospital' was the common designation given to these institutions in Australia and between 1920 and 1928 attendants became nurses following the enactment of nurse registration legalisation across the States (Durdin, 1991). Their roles were closely modelled on general hospital nursing roles; they became doctor's aides and assisted in physical interventions on patients, such as cold baths and 'insulin coma therapy' (Nolan, 1998). As the century progressed, treatment became increasingly focused on the use of medications under the medical model treatment (Evans, 2013). During the 1960s and 1970s mental health services began developing care and treatment services in the community, while maintaining stand-alone specialist psychiatric hospitals (Rosen, 2006).

Since the 1980s, there has been rapid changes in Australia to the way mental health services have been delivered (Mental Health Nurse Education Taskforce, 2008). These reforms ultimately saw a process of 'deinstitutionalisation'. Most large stand-alone institutions have closed, and their long stay populations transferred to a variety of alternative living arrangements. Acute inpatient services have been integrated into general health settings, such as major hospitals, known as 'mainstreaming' (Happel et al., 2008).

Thirty years of deinstitutionalisation in Australia have seen the number of specialised mental health beds in public mental health services decrease from approximately 30,000 to 7,057

(Australian Institute of Health and Welfare, 2017). Criticisms have been expressed about the process of 'deinstitutionalisation', based on the perception that it created gaps in service delivery systems (Rosen, 2006). Critics of the changes have also highlighted their beliefs that not enough resources have been put in place to adequately support people and their carers' (Happel et al., 2008). As the emphasis of services has moved from a hospital-focus to a community-focus, inpatient units in public mental health services are now a place of last resort (Happell, 2009). In these units, nurses manage people who are deemed to be of high risk to themselves and/or to others and who are no longer suitable for community management (Beckett et al., 2013). However, the experience of both staff and service users in inpatient mental health units continues to be an issue of concern in Australia, with these clinical environments being noted as being non-therapeutic, unsafe and depersonalising (Beckett et al., 2013).

Mental health nursing in Australia (like the mental health workforce generally) has experienced a rapid pace of change in its work context in its recent history and nurses are now caring for more-complex consumer groups who have shorter inpatient stays than was previously the case (Mental Health Nurse Education Taskforce, 2008). As alluded to in the previous section, there have also been changes in the training of mental health nurses over this period as Australia moved away from direct entry hospital-based specialist training (as specialist hospitals have closed) to university-based 'comprehensive' undergraduate degree preparation for practice and a generic nursing qualification. This change in the approach to mental health nursing education has drawn strong criticism for failing to adequately prepare students for mental health practice (Happell & Cutcliffe, 2011).

1.7 Mental health nursing and Aboriginal and Torres Strait Islander peoples.

Hellsten and Hineroa (2013) found that there are many challenges faced by mental health nurses caring for Aboriginal and Torres Strait Islander peoples in mental health services. One of these is that there is a dearth of knowledge related specifically to the area of mental health nursing and Aboriginal and Torres Strait Islander peoples (Bradley, Dunn, Lowell, & Nagel, 2015). In attempting to understand the accumulated specialist knowledge on mental health nursing practice and Aboriginal and Torres Strait Islander peoples, I undertook a review of published literature (Hart, 2018). This review had a specific focus on identifying published literature with a specific focus on the area of mental health nursing practice with Aboriginal and Torres Strait Islander people in the mental health care settings. The search sought peer-reviewed literature from 1995 to 2018 (February). This included research papers, reflective papers and review papers published in refereed journals. 1995 was selected given that this was deemed as the relevant period for the emergence of this topic in the literature and links clearly with the period of health policy development in this area (Swan & Raphael, 1995; Commonwealth of Australia, 2004). 2018 was selected as it was the year that this thesis was written. Search terms used were: Psychiatric Nur*, Mental Health Nur*, Mental Health Professional*, Mental Health Staff, Mental Health Personnel, Mental Health Service. Austral*, Aborigin*, Indigenous, and Torres Strait. Abstracts were reviewed through an analysis of the text words contained in the title and abstract and the index terms used to describe the article. Finally, the reference list of the identified articles was hand searched for additional studies.

The databases searched included:

CINAHL

Cochrane Library

ScienceDirect

Embase

Indigenous Collection (Informit)

Joanna Briggs Institute EBP Database

MEDLINE

Google Scholar

PsycINFO

Australian Indigenous Health InfoNet

It became apparent that there is very little published literature specifically relating to mental health nursing practice and Aboriginal and Torres Strait Islander peoples. Eight papers where identified, in which there was a specific focus on mental health nursing practice and Aboriginal and Torres Strait Islander people. This literature tended to be opinion-based or reviews of literature, with little primary research undertaken in the area. The available literature with a specific focus on mental health nursing care of Aboriginal and Torres Strait Islander peoples is summarised in Table 1. Papers that have been published related to this study have not been included in this review.

Some of the papers retrieved from the literature review give us an understanding of how the authors constructed a specialist practice with Aboriginal and Torres Strait Islander people (Hart, 2018). For Proctor (2005, p. 240), mental health nurses should acknowledge 'the social, cultural and historical factors when assessing risk factors and [use] the language of "emotional and social well-being" defined broadly and in a culturally congruent way' in their communication with Aboriginal and Torres Strait Islander people. Mental health nursing practice would involve a process of nurses learning from Aboriginal and Torres Strait Islander people, as they learnt from mental health nurses as care providers (Proctor, 2005). Trueman (2013a, p. 715) viewed mental health nursing with Aboriginal and Torres Strait Islander people as a practice requiring 'cultural competence in linguistic communication as well as in caring

and interacting with Aboriginal clients by appreciating the cultural, historic, economic, and political factors contributing to their symptom presentation.' Mental health nursing practice from 'a Western bio-medical and mainstream/urban service provision model' could lead to inappropriate care, a lack of engagement by the Aboriginal and Torres Strait Islander person, and 'ultimately service delivery failure' (Trueman, 2013a, p. 715).

My paper written with John Grootjans written before the commencement of my PhD study argued that specialist practice should be guided by the concept of cultural safety. Cultural safety is reflective model that requires nurses to explore and identify assumptions surrounding their nursing care and how they affect the care they provide (Ramsden, 2002). Effective nursing care can only be determined by the recipient of care (Ramsden, 2002). As authors, we argued that cultural safety could guide care that was focused on the person, promote cultural integrity and support recovery (Molloy & Grootjans, 2014). Trueman (2017) used the concept of cultural safety to reflect on his care as a mental health nurse. To improve mental health nursing care, nurses needed to recognise and be aware of Aboriginal and Torres Strait Islander history and cultural difference and to be culturally safe in their practices (Trueman, 2017).

There was limited primary research specifically related to mental health nursing and Aboriginal people found in the review. In their action research study focusing on Aboriginal mental health and safe medication management, De Crespigny and colleagues (2006) found low levels of understanding amongst non-Indigenous mental health nurses about the social, historical, and economic determinants of poor mental health in Indigenous communities to be pervasive. The authors suggested shaping mental health nursing care through education to be culturally respectful and 'client- and family-focussed' (De Crespigny et al., 2006).

Author	Title	Type	Focus
Trueman (2017)	Indigenous clients intersecting with mainstream nursing: a reflection.	Reflective paper	The paper presents two of the author's reflections on practice with Aboriginal and Torres Strait Islander people in mental health settings. It identifies the care provided as culturally inappropriate.
Molloy & Groojans (2014)	The Ideas of Frantz Fanon and culturally safe practices for Aboriginal and Torres Strait Islander People in Australia	Review	The paper considers the ideas of the writer Frantz Fanon and their potential for promoting culturally safe nursing practice in mental health services in Australia.
Trueman (2013a)	Contextualizing mental health nursing encounters in Australian remote Aboriginal communities: Part I, history and customs.	Review	This paper focuses on the history and cultural beliefs and customs of Aboriginal Peoples that are viewed to be crucial to delivery of culturally competent mental health care.
Trueman (2013b)	Contextualizing mental health nursing Encounters in Australian remote Aboriginal communities: Part 2, client encounters and interviews	Review	The paper focuses on information for mental health nurses for client encounters and mental health interviews and treatment with Aboriginal peoples.
O'Brien & Jackson (2007)	It's a long way from the office to the creek bed: Remote area mental health nursing in Australia	Qualitative, interpretative study.	The papers explore how mental health nurses experience working in remote communities and how they developed relevant knowledge and skills. The participants adapted and developed ways of working at the interface of another culture and also derived personal and professional benefit from the experience.
O'Brien et al. (2006)	Administering the New Zealand professional practice audit questionnaire to mental health nurses in Australia based on the Australian and New Zealand College of Mental Health Nurses' standards	Survey	This paper describes the survey of 85 mental health nurses in Queensland and New South Wales using a modified version of the Professional Practice Audit Questionnaire from New Zealand. All references to Māori were changed to Aboriginal and Torres Strait Islander peoples. University-trained nurses had a higher affinity to cultural safe practice with Aboriginal and Torres Strait Islander peoples than hospital-trained nurses. There was uncertainty amongst all nurses in relation to their advocacy role for Aboriginal and Torres Strait Islander people. Females rated higher on cultural safe practice than males.
De Credpigny et al. (2006)	A nursing partnership for better outcomes in Aboriginal mental health, including substance use.	Action Research	The paper draws on participatory action research findings and interventions, such as advocacy and professional education, as applied during and after a large project focusing on Aboriginal mental health and safe medication management.
Proctor (2005)	Parasuicide, self-harm and suicide in Aboriginal people in rural Australia: A review of the literature with implications for mental health nursing practice	Review	The paper offers an opinion on role of mental health nursing being crucial to the success of any intervention project focused on parasuicide, self-harm and suicide with Aboriginal and Torres Strait Islander peoples

Table 1. Identified studies with a sole focus on mental health nursing practice and Aboriginal and Torres Strait Islander peoples.

While O'Brien & Jackson (2007) in their qualitative, interpretative research study noted that mental health nurses had to shift their focus from the individual to family and community relationships to develop effective nursing relationships to support Aboriginal and Torres Strait Islander users of public mental health services. The authors note that the mental health nurses 'struggled with the shift from the individually focused Westernized view of people' (O'Brien & Jackson, 2007, p. 139). O'Brien and colleagues (2006) surveyed 85 mental health nurses in Queensland and New South Wales using a modified version of the Professional Practice Audit Questionnaire from New Zealand, in which one of the clinical audit indicators was related to culturally safe care. Although originally referring to Māori people, the modified audit tool was changed to reference Aboriginal and Torres Strait Islander peoples. The findings highlighted that there was uncertainty amongst all nurses in relation to their advocacy role for Aboriginal and Torres Strait Islander people (O'Brien, Gaskin, & Hardy, 2006). Of the nursing group surveyed, university-trained nurses had a higher affinity for cultural safe practice with Aboriginal and Torres Strait Islander peoples than hospital-trained nurses. Females rated higher on cultural safe practice than males.

Beyond the literature where the sole focus was on mental health nursing, there is literature where mental health nurses formed parts of the cohorts studied, which can give us insights into professional practice in this area. Durey and colleagues (2013) surveyed ninety medical, nursing and allied health staff working in a forensic mental health service in Western Australia and later interviewed ten of this group. The survey and interview findings suggested that the health professionals wanted to improve care to Aboriginal and Torres Strait people in the service but were constrained by the forensic setting and restrictions of policies and practices in the forensic mental health service. The interviewees identified the importance of a holistic approach to care that were respectful of cultural differences and acknowledged the sociohistorical context, including the impact of colonisation, while at the same time being

unsure how to best do this in a therapeutic encounter (Durey, Wynaden, Barr, & Ali, 2013). McGough and colleagues (2018) studied twenty-five mental health nurses and three psychologists who worked in Western Australia's public mental health services, to explore their experiences of providing culturally safe practice with Aboriginal and Torres Strait Islander people. The group felt unprepared for care with this group of service users and had limited understanding of the concept of cultural safety (McGough et al., 2018). The findings highlighted the relationship between Indigenous historical experiences, generational trauma, the experience of racism and current Indigenous health care outcomes was not clearly identified by participants (McGough et al., 2018). While Isaacs and colleagues (2012) included two mental health nurses in their study which included Indigenous service users, their carers and both Indigenous and non-Indigenous health care workers. Mental health service staff highlighted the need for their service delivery to be flexible to the needs of Indigenous users of the service, including the use of mobile outreach, and the need to provide key roles for the family in the person's care (Isaacs, Maybury, & Gruis, 2012).

Focusing on Aboriginal and Torres Strait Islander users of public mental health services, both Sambrano and Cox (2013) and Bradley and colleagues (2015) draw implications for mental health nursing from their findings. Sambrano and Cox's (2013) phenomenological study of Aboriginal and Torres Strait Islander people's experiences of seclusion, recommends that mental health practice needs to consider the social and cultural factors that influence this groups experience of seclusion. Although noting the distress that all consumers can feel from seclusion, the authors argue 'that this humiliating, degrading, and dehumanizing treatment mirrors their experience in the wider society' and as such sociocultural factors could be incorporated into the decision-making process nurses' undertake when considering secluding Aboriginal and Torres Strait Islander people (Sambrano & Cox, 2013, p. 528). In their literature on acute service delivery for Aboriginal and Torres Strait Islander women, Bradley and

colleagues (2015) noted limited relevant literature related to this service user group and the need for focused research to assist in the delivery of culturally secure care.

The literature reviewed points to the importance of the concepts of social and emotional wellbeing and cultural safety in approaching mental health nursing practice with Aboriginal and Torres Strait Islander peoples (Proctor, 2005; Durey et al., 2013; Trueman, 2013a; Sambrano & Cox, 2013; Molloy & Grootjans, 2014; Trueman, 2017; McGough et al., 2018). The literature also emphasises the importance of social, cultural and historical factors relevant to Aboriginal and Torres Strait Islander peoples and their implications for care (Proctor, 2005; Durey et al., 2013; Trueman, 2013a; Sambrano & Cox 2013; Molloy & Grootjans, 2014; Trueman, 2017; McGough et al., 2018). Another key issue that comes out of the research papers is that nurses do not feel prepared for or confident in this area of practice (O'Brien et al., 2006; De Crespigny et al., 2006; O'Brien & Jackson, 2007; McGough et al., 2018).

Professional healthcare practice with Aboriginal and Torres Strait Islander peoples is influenced by the health professional's attitudes and understandings (Dudgeon & Pickett, 2000). Given that there are limitations in mental health nursing's body of knowledge, it becomes unclear what understandings underpin practice. Mental health nursing practice with Aboriginal and Torres Strait Islander peoples, as in any area of nursing practice, can be informed by a broad knowledge-base. This can include the history of Indigenous Australia including the impact of colonisation (Goold, 2001) and the role of the nursing profession in this history (Forsyth, 2007); knowledge about trauma (Brown, 2001; O'Brien, 2005); racism (Trueman, Mills, & Usher, 2011; O'Brien, 2005); cultural competence (Goold, 2001; Walker & Sonn, 2010); cultural safety (Trueman, 2017); as well as mental health approaches such as the ideas of recovery-orientated practice (Sayers, Cleary, Hunt, & Burmeister, 2017). All these areas can be drawn upon to inform mental nursing practice for Aboriginal and Torres Strait

Islander peoples. However, how mental health nurses make choices from this broad knowledge-base, and the impact that this has on practice with Aboriginal and Torres Strait Islander peoples, is not clear.

What has become clearer since the fieldwork took place are the requirements of practice for mental health nurses from the profession's regulatory body. In February 2018, the Nursing and Midwifery Board of Australia identified the need for the regulations and codes establishing professional standards for nursing to clearly communicate the requirement for cultural safety (Nursing and Midwifery Board of Australia, 2018a). The Code of Conduct (Nursing and Midwifery Board of Australia, 2018b, p. 9) identifies that nurses practising in Australia must:

- acknowledge that Australia has always been a culturally and linguistically diverse nation. Aboriginal and/or Torres Strait Islander peoples have inhabited and cared for the land as the First Peoples of Australia for millennia, and their histories and cultures have uniquely shaped our nation
- require nurses and midwives to understand and acknowledge the historic factors, such as colonisation and its impact on Aboriginal and/or Torres Strait Islander peoples' health, which help to inform care. In particular, Aboriginal and/or Torres Strait Islander peoples bear the burden of gross social, cultural and health inequality, and
- provide clear guidance and set expectations for nurses and midwives in supporting the health of Aboriginal and/or Torres Strait Islander peoples.
- provide care that is holistic, free of bias and racism, challenges belief based upon assumption and is culturally safe and respectful for Aboriginal and/or Torres Strait Islander peoples
- advocate for, and act to facilitate, access to quality and culturally safe health services for Aboriginal and/or Torres Strait Islander peoples, and

- recognise the importance of family, community, partnership and collaboration in the healthcare decision-making of Aboriginal and/or Torres Strait Islander peoples, for both prevention strategies and care delivery.

1.8 The need for a study

Beyond my individual questions about practice, there is a wider need for a study ethnographically focused on mental health nursing practice and Aboriginal and Torres Strait Islander peoples. This is due to the ongoing criticism of the appropriateness of public mental health services and the practice of mental health professionals, as well as the relative silence of mental health nursing on these issues. Ethnography can contribute to our understandings of current practices and attitudes, as well as developing an in-depth description of current systems and processes with Australia's public mental health services. Such insights are important in the understanding of the position of mental health nursing within the context of the broad criticism of services and practice. It will also provide an understanding as to where improvements in the delivery of mental health nursing can be focused.

1.9 Research aims and research question

The aim of this research was to undertake an ethnographic analysis of the culture of mental health nursing in relation to its practice with Aboriginal and Torres Strait Islander users of public mental health services. The question I followed from the start of the research was:

What beliefs do mental health nurses have about nursing care and Aboriginal and Torres Strait Islander peoples in public mental health services, and how are these expressed in practice?

1.10 Scope of the study

All the participants I talked with over the course of this research identified as non-Indigenous. The study, therefore, represents a social analysis of a group of non-Indigenous mental health nurses in regards their practice with Aboriginal and Torres Strait Islander peoples. This, of course, is a restriction on the scope of this study, presenting only a few voices in a multivocal story. However, given the relative silence on this issue in relation to research amongst the speciality of mental health nursing, I believe it to be important to add these findings to our understandings of relationships that are complex and interconnected (Marcus & Fischer, 1996).

1.11 Organisation of thesis

This is a manuscript-based thesis and differs from the traditional monograph thesis form. The thesis is divided in ten chapters. Two of the chapters related to methodology (chapters 2 and 3) are published manuscripts. Of the five findings chapters, three are published manuscripts (chapters 5, 6, 7). The additional findings chapter (chapters 8 and 9) are manuscripts that have been submitted to journals for review for publication. The thesis has been organised in the following chapters:

Chapter 1 Introduction

This chapter introduces the study presented in this thesis. It provides an overview of relevant literature and describes the organisation of the thesis.

Chapter 2 Methodological findings: Ethnonursing and the ethnographic approach in nursing.

This published journal article presents a methodological review of the ethnonursing research method. It explores the history of modern ethnography from the 'golden age' in the first half of the 20th century up to the critiques of the foundations of traditional ethnography that developed from the 1970s onwards. The article argues that the ethnonursing research method has failed to respond to contemporary issues relevant to ethnographic knowledge and that there is a need to refresh the method.

Chapter 3 Methodological findings- Shared worlds: multi-sited ethnography and nursing research

This published journal article presents a methodological review of multi-sited ethnography. It examines the concept of 'the field' in ethnography and how cultural identities can exist without reference to a specific location and extend beyond regional and national boundaries. Multi-sited ethnography provides a method of contextualising multi-sited social phenomenon. The article contends it is particularly suited to nursing research as it provides researchers with an ethnographic method that is more relevant to the interconnected world of health and health services.

Chapter 4 Research methods

This chapter provides details on methods used in the conduct of this multi-sited ethnography. It identifies issues in relation to ethnographic fieldwork, data collection and data analysis. It also describes the challenges encountered in planning research across multiple sites.

Chapter 5 Nursing care and Indigenous Australians: An autoethnography

This published journal article presents an autoethnography on my own experiences working as a mental health nurse caring for an Aboriginal person. The research used written journal reflections to critically explore culture within a public mental health service as it related to the treatment and care of Aboriginal and Torres Strait Islander peoples. The article provides my analysis of how the mental health service was dominated by a biomedical model of treatment and care. The care practices that developed under this dominance were unable to respond appropriately to the mental health needs of Aboriginal and Torres Strait Islander peoples.

Chapter 6-More satisfying than factory work: An analysis of mental health nursing using a print media archive.

This published journal article presents a review of Australian print media, with a key focus on newspapers, published between 1924 and 1999. This review was undertaken in my attempts to understand the professional past of mental health nursing. The historical sources provided a means to contextualise the present circumstances of mental health nursing in Australia. The article argues a profound change experienced by the profession over its recent history has been the erosion of the mental health nursing identity in Australia. The loss of the stand-alone hospital system, direct entry specialist training, and specialist professional registration have left mental health nursing with a growing uncertainty about itself as a speciality within nursing.

Chapter 7 Lip service: public mental health services and the care of Aboriginal and Torres Strait Islander peoples.

This published journal article explores the beliefs and ideas that mental health nurses identified about public mental health services and the services they provided to Aboriginal and Torres Strait Islander people. It presents finding from fieldwork, where mental health nurses described

the constricting effect of the biomedical paradigm of mental illness within these services and the impact this had on their abilities to provide appropriate care for Aboriginal and Torres Strait Islander peoples.

Chapter 8 Mental health nursing practice and Aboriginal and Torres Strait Islander peoples: A multi-sited ethnography

This manuscript focuses on the area of specialist mental health nursing practice and Aboriginal and Torres Strait Islander peoples. This research found a disunited approach to practice during the fieldwork. Practice was expressed as a series of individual constructions built upon the nurses' beliefs about Aboriginal and Torres Strait Islander peoples and their experiences in practice with these peoples.

Chapter 9 Encounters with difference: Mental health nurses and Indigenous Australian users of public mental health services

This manuscript examines mental health nurses' beliefs about the Aboriginal and Torres Strait Islander peoples they have encountered in public mental health services. Throughout this research a recurring element in mental health nurses' conversations about Aboriginal and Torres Strait Islander people was a focus on their *otherness*. This included description of alterity they had found in practice and how their ideas of *otherness* influenced their mental health nursing care. Despite an emphasis on differences with Aboriginal and Torres Strait Islander people, what this meant for mental health nursing practice was not clear.

Chapter 10 Conclusion

In the last chapter, I return to answer explicitly the research question outlined in Chapter 1. The chapter also highlights the implications of the findings for mental health nursing, presents limitations of the study and suggest areas for future research.

Chapter Two. Methodological Findings: Ethnonursing and the ethnographic approach in nursing

2.1 Prologue

This chapter serves as a preamble to the research methods and approach to the study presented in Chapter 4 and focuses on considerations in relation to the use of ethnography in nursing research. Before undertaking this study, I had an awareness of the ethnonursing method (Leininger, 1985) from my postgraduate studies. It seemed logical that an approach to ethnographic research developed by a nurse for nurses (Leininger, 1997) could potentially provide the methodology to guide a study of nursing culture (Gerbu & Willman, 2003).

Returning to ethnonursing, after having read widely on contemporary ethnography, I found a method that had failed to respond to the significant critiques of ethnographic methodology in the last quarter of the twentieth century. The publication presented in this chapter provides a methodological review of ethnonursing which includes a summary of the method, critical comment on it related to concepts from contemporary anthropology and offers suggestions for its revision.

2.2 Ethnonursing and the ethnographic approach in nursing.

Molloy, L., Walker, K., Lakeman, R., & Skinner, I. (2015). Ethnonursing and the ethnographic approach in nursing. *Nurse Researcher, 23*(2), 17-21.

Molloy, L., Walker, K., Lakeman, R., Skinner, I., 2015. Ethnonursing and the ethnographic approach in nursing, Nurse researcher, 23(2), 17-21

2.3 Conclusion: Relevance for thesis

The published journal article presented in this chapter provides a methodological review of the ethnonursing method. The critique of ethnography that accelerated from the 1980s onwards has undermined the belief systems that provided the theoretical foundations of traditional approaches to ethnography, including ethnonursing. The idea that ethnographic research establishes unbiased truths regarding a group of people is not in keeping with the contemporary discourse of ethnography.

In developing this research study, I explored the epistemologies of ethnography that developed in anthropology following the critiques of the postmodern project. From this scholarship, I identified multi-sited ethnography as a method that had synergy with the research aims. The next chapter explores multi-sited ethnography in more detail.

Chapter Three. Methodological Findings: Shared worlds: multi-sited ethnography and nursing research

3.1 Prologue

Ethnographic studies of mental health nursing culture in Australia have generally focused on single sites of practice, including inpatient units (Cleary, 2004; Hamilton, 2009; Palmer, 2012; Due, Connellan & Riggs, 2012) and community health centres (Muir-Cochrane 2001). Less common are ethnographic studies that go beyond service boundaries. One example was Grigg and colleagues (2004), who undertook an ethnographic study of two mental health services in Melbourne, focused on mental health nurses in triage services. In undertaking this ethnographic study, I initially mused over focusing on a mental health unit integrated into a large general hospital, or a mental health service with its selection of inpatient and community services. However, when I reflected on the area of professional culture that I wanted to explore, I thought of it as being something that was not particular to a single site or service.

Mental health nursing practice in public mental health services exists in many sites simultaneously, and I had perceived differences in the sites of practice I had encountered through my own professional experience. Despite these local differences, I also perceived a 'shared world' of practice (Marcus, 1999, p. 7). I had experienced this in conferences, at training workshops and meetings, where I met nurses from other mental health services. I saw it recorded in textbooks, websites and journal articles. Therefore, a key consideration for this study was utilising a method that could enable a social analysis of mental health practice across Australia. The field of this research was not bounded geographically, given the social nature of my phenomenon of interest (Clifford, 1997).

In my readings related to ethnography, multi-sited ethnography appeared to provide an approach to undertaking ethnographic research within a field of this nature. The published journal article presented in this chapter presents a review of the methodology and explores implications when the methodology is applied in the health setting.

3.2 Publication

Molloy, L., Walker, K., & Lakeman, R. (2017). Shared worlds: multi-sited ethnography and nursing research. *Nurse Researcher, 24*(4), 22-26.

3.3 Conclusion: Relevance for thesis

The published journal article presented in this chapter provides a methodological review of multi-sited ethnography and its possibilities with nursing research. The choice of research phenomenon, namely mental health nursing practice, influenced the sites selected for the research. Interviews with mental health nurses from across Australia and fieldwork in formal gatherings of mental health nurses and two mental health services in different States appeared as a way of explicating a 'shared world' of mental health nurses in public mental health services. The following chapter explores the methods of this research in more detail.

Chapter 4. Research Methods

4.1 Introduction

In the two previous chapters, I undertook methodological reviews that explored ethnonursing, ethnography and multi-sited ethnography in regards their relevance to nursing research. I argued that multi-sited ethnography provided a method to explore the social realities of mental health nurses and contextualise the multi-sited social phenomenon of mental health nursing practice. I will now explain how from this methodological philosophy and approach; I have constructed this research study.

Although the previous chapter provided a brief overview of the study in the paper it presented, Chapter 3 of this thesis describes the methods used in detail.

4.2 The study

The data collection for this study took place between February 2014 and October 2016. I used multiple qualitative research methods in the collection of data. They included in-depth, semi-structured interviews (McIntosh & Morse, 2015), observational fieldwork (Van Maanen, 2011), fieldnotes (Emerson, Fretz, & Shaw, 2011) and document analysis (Bowen, 2009). Data was recorded in fieldnotes and interview transcripts. Utilising a variety of methods allowed me to access a rich diversity of information on mental health nursing practice (Hammersley & Atkinson, 2007). This approach to data collection helps broaden understandings of the phenomenon of interest and enables thick description in the data (Warren & Karner, 2010). In

planning an inquiry of the culture of mental health nursing as it related to the care of Aboriginal and Torres Strait Islander users of public mental health services, I had many discussions of my ideas about the 'field' of the research with my supervisors and my mental health nursing peers. I planned to study at least two mental health services to strengthen my understanding of practices across sites, and there seemed to be interesting possibilities for the analysis if the study explored services in a regional/rural area and in an urban area. I also wanted to use interviews as a way of connecting with practice and service provision beyond the chosen sites for observational fieldwork, as this would allow nurses to be recruited from across Australia. The assemblage of sites in which data was collected ultimately included the following:

Interviews

In-depth, semi-structured interviews were undertaken with 17 registered nurses who had experience providing care to Aboriginal and Torres Strait Islander users of public mental health services. In-depth interviewing enables the ethnographer to explore people's experiences, behaviours and opinions from the participant's perspective (Rubin & Rubin, 2012). Such a level of depth was important in developing my understandings of this area of practice (Gerard Forsey, 2010). The interviews ranged in length from 30 to 70 minutes. Interviewees chose pseudonyms and read a participant information sheet (see Appendix A) had time to consider participation and signed a consent form prior to the interview (see Appendix B). The interviewees were recruited during the fieldwork in mental health services (six interviewees) and through an email on the Australian College of Mental Health Nurses Aboriginal and Torres Strait Islander Special Interest Group e-mailing list (eleven interviewees) (see Appendix C for email). The nurses had experience practising in public

mental health services in New South Wales, Victoria, South Australia, the Northern Territory, the Australian Capital Territory, Queensland and Western Australia. Interviews were carried out face-to-face with most of the nurses. However, interviews using phone and Skype were required for five of the interviewees due to my inability to travel the distances required for a face-to-face interview. From a data collection perspective, I did not find any of the communication channels used superior to another for building rapport and gathering data, although one of the interviews on Skype was made challenging due to a slight delay in transmission.

A semi-structured interview schedule was used to guide the interviews (see Appendix D). All of the interviewees provided detailed responses to the questions posed to them. Conducting interviews individually provided distinct accounts from interviewees about their practice and experiences. When taken as a group of interviews, the narratives also provide clusters of themes that were common across the interactions (Bell, 1987). After the interviews, I recorded fieldnotes on the experience of the interview from my perspective. The digital recordings of the interviews were later transcribed verbatim. The majority of the interviews occurred ahead of the nonparticipant observation in mental health services and provided useful insights on practices and service provision that guided my approach to fieldwork. Details from the interviews that could have potentially breached the participant's anonymity, such as the identification of mental health services in which they worked, were expunged.

Fieldwork

Observational fieldwork is a form of inquiry in which the ethnographer is 'immersed personally in the ongoing social activities of some individual or group for the purposes of research' (Wolcott, 2005, p. 58). Observation provides a method for gaining a contextualised understanding of social behaviour (Hammersley & Atkinson, 2007) and can generate thick description of the social world (Geertz, 1973). The fieldwork in this study involved observations in formal gatherings of nurses in which I was an active participant and observations in practice settings, where I did not participate in the nurses' activities.

Participant observation took place at two mental health nursing conferences. These were the Australian College of Mental Health Nurses 40th International Mental Health Nursing Conference in Melbourne on the 6th to the 9th of October 2014 and the Australian College of Mental Health Nurses Greater Western Sydney Conference in Parramatta on the 27th of March 2015. The conferences offered a space to hear from presenters about current practice and engage with attendees about their ideas on practice in the public mental health service setting. I also identified my research area to attendees I met during the conferences and had conversations with them around their ideas about this area. I recorded fieldnotes on my observations and interactions.

I undertook nonparticipant observation in mental health services. These were St. Vincent's Mental Health Service covering an area of inner city Sydney in New South Wales and Cairns and Hinterland Hospital and Health Service covering a regional city and rural and remote areas in Far North Queensland. A letter of support for the study was received from the Programme Directors of both services who had been briefed about the proposed research, prior to undergoing ethical review and receiving approval from local research ethics committees.

The first service that I studied was Cairns and Hinterland Hospital and Health Service. Fieldwork took place over five days in February 2016. During this time, I observed within the mental health team attached to the emergency department and the acute inpatient team in a hospital setting. I visited two community mental health teams situated in rural areas and a community crisis team based in the regional city of Cairns. Nursing staff in this service highlighted that they provided care to high numbers of Indigenous service users. The demographics of the local catchment highlighted the Aboriginal and Torres Strait Islander population being approximately 10 percent of the overall population. The second service that I studied was St. Vincent's Mental Health Service. Fieldwork took place over five days in October 2016. During this time, I observed within the community mental health team, the psychiatric emergency care centre team and the acute inpatient team. All observations of these teams took place in the hospital setting, where the teams were based. Staff in this service identified that they had small numbers of Indigenous service users. The demographics of the local catchment highlighted the Aboriginal and Torres Strait Islander population being approximately 1.5 percent of the overall population. I recorded fieldnotes related to the fieldwork throughout the research, which included twenty-eight conversations with mental health nurses about their practice with Aboriginal and Torres Strait Islander service users. I also recruited six nurses for in-depth, semi- structured interviews in both services (See Appendix E for poster).

Fieldnotes

Fieldnotes are the most common method associated with ethnography. They are the written account created by the ethnographer that record their reflections, observations and experiences during the research (Emerson et al., 2011). They are intended to produce an understanding of the social situation being studied (Schwandt, 2015). During observational fieldwork, I would write notes at regular points in the day and would later record detailed fieldnotes about my observations after leaving the site at night time. My fieldnotes contain descriptions of interactions with people, observed practices, the physical environments I entered, organisational routines I encountered, and my reflections.

Although intimately linked to observational research, I did not limit myself to recording fieldnotes during the observational sections of the study. I recorded them throughout the research as a means of reflexivity. These reflective writings focused on my position and biases in the process of inquiry (Elliott, Ryan, & Hollway, 2012). I also used them to record details of my document analysis and my thoughts about my reading. As stated earlier in the chapter, I recorded fieldnotes related to the in-depth interviews.

Document analysis.

During the period of the research, I undertook regular reviews for, and analysis of, relevant documents, including scholarly literature, professional and health service documents, government publications, websites and historical documents related to the speciality. These sources provided a means of exploring the field of mental health services and mental health nursing practice beyond the boundaries of the observational fieldwork and the interviews

(Murchison, 2010). I recorded fieldnotes on my engagement with the sources and how their ideas influenced my thinking.

4.3 Data analysis

An ethnography is ultimately the collection of data from across many situations (Latimer, 2008). Although the data itself may be qualitatively different, taken together, it can provide the basis of an analysis of how social worlds are constructed (Latimer, 2008). Data collection and analysis occurred iteratively throughout the ethnography. Data was grouped together to explore similarities and differences in the accounts of the interviewees, and my observations and reflections in my fieldnotes (Corbin & Strauss, 2008). This analysis informed future stages of data collection. The combination of fieldnotes and interviews was a strength in the analysis as their data could further illuminate the other (Hammersley & Atkinson, 2007).

I read and reread the texts generated by the research, allowing for an inductive approach in my efforts to analyse the data I had collected (Pope, Ziebland, & Mays, 2000). I used an analytic strategy for interview transcriptions and fieldnotes adapted from what Corbin and Strauss (1998, 2008) describe as open coding, axial coding, and selective coding. Strauss and Corbin (1998, p 4) have described how their approach 'offers a cluster of very useful procedures – essentially guidelines, suggested techniques, but not commandments' and that the researcher should 'use the procedures in their own way' (Corbin & Strauss, 2008, p. x). Grounded theory methods provide flexible strategies for ethnographers that can create astute analyses (Charmaz & Mitchell, 2001). These methods offer 'a set of methodological steps to retrieve lived social life' (Tavory and Timmermans, 2009, p. 248), and can be used to understand people's thoughts and behaviour, complementing ethnographic research aims (Charmaz, 2006). They provide a

focused approach within an ethnography to examine, interpret and find meaning in data generated from multiple sources, including fieldnotes and interviews (Bamkin, Maynard, & Goulding, 2016).

For this study, the analytical strategy was used to guide the qualitative data coding technique, not as a means of constructing a grounded theory (Blair, 2015). It provided an approach to data analysis that was both systematic and coordinated (Robson, 2002). While combining elements from grounded theory with other methodologies has been disapproved of by purists, it has become an accepted approach in research, including ethnography (Charmaz & Mitchell, 2001; Charmaz, 2006; Tavory and Timmermans, 2009; Bamkin et al., 2016; Alias et al, 2018). The process of data analysis included:

Open coding

The aim of open coding is to identify discrete concepts (Corbin & Strauss, 2008). In my initial steps, I scrutinised the fieldnotes and interview transcripts line-by-line and labelled words and phrases that conveyed meaning and developed categories of information (Corbin & Strauss, 2008). Corbin and Strauss (2008, p. 195) describe this process as 'Breaking data apart and delineating concepts to stand for blocks of raw data. At the same time, one is qualifying those concepts in terms of their properties and dimensions'. I rather self- consciously asked questions of the data initially, but as I continued, I found the strategy of questioning the data (Who, when, where, what, how, why?) and making comparisons enabled me to open up the text by dividing it into smaller units for analysis (Corbin & Strauss, 2008). These consisted of sections of the text or sentences, with each being significant to the area of mental health nursing and its practice with Aboriginal and Torres Strait Islander peoples. I studied and compared these units to discover similarities and differences, allowing me to identify concepts (Corbin & Strauss, 2008). As my analysis progressed, I sorted the concepts that had been generated into groups where there was clear connections and identified these as categories (See Appendix G for a list of categories

generated through open coding).

Axial coding

Between the 2nd edition and 3rd edition of their book Basics of Qualitative Research (Strauss & Corbin, 1998; Corbin & Strauss, 2008), the authors discuss how the distinctions between open coding and axial coding identified in the earlier of the works was artificial and used for explanatory processes only, noting that the two approaches go hand in hand. This reflects my own experience. As the ethnography progressed, I found the analytical strategies made me sensitive to both breaking the data apart, but also to seeing the connections that would bring it back together again (Corbin & Strauss, 2008). Corbin and Strauss (2008) recommend that the focus in the axial coding phase be placed on the context and process. The context is defined as 'structural conditions that shape the nature of situations, circumstances, or problems to which individuals respond by means of action/interaction/emotions' (Corbin & Strauss, 2008, p 87). While the process is defined as 'The flow of actions/interaction/emotions that occur in response to events, situations, or problems.' (Corbin & Strauss, 2008, p. 87). I found this focus complimented my need to contextualise a multi-sited social phenomenon (Marcus, 1999).

I continued to make comparisons and question the categories identified in open coding. Through focusing on context and process, axial coding enabled me to develop and identify the relationships between categories. The inductive process derived the five categories, namely 'biomedical creep', 'lip service'; 'respecting the difference', 'a specialist practice', and 'mental health nursing and the Other'. (See Appendix H for an example of axial coding).

Selective coding

The final process identified by Corbin and Strauss (2008), selective coding involves choosing one category to be the core category and relating all other categories to that category. Charmaz and Mitchell (2001) identify that tension can exist between grounded theory and ethnography, as they have different emphases. This procedure, developed for generating theory was one where I felt such a tension (Becker, 1998). Strauss and Corbin (1998, p. 146) noted that it is essential that categories are integrated to form 'an explanatory whole' from the research findings. Multi-sited ethnography does not aspire to creating an idealised holism (Mitchell, 2012). Therefore, in this research I did not choose one category to be the core category but integrated of the categories developed in axial coding within an ethnographic analysis of mental health nursing culture and presented the findings as an ethnography. Therefore, data analysis was confined to open and axial coding.

4.4 Research ethics

The National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council (NHMRC), 2007) sets the standards for Human Research Ethics Committees (HREC) and researchers in Australia. The standards include principles of research merit and integrity, beneficence, respect and justice. The multi-sited approach taken in this research meant that the research proposal for the study was reviewed by three separate HRECs. The study received its overall approval from the HREC (Tasmania) network (Study identifier: H0014330). It also received ethical approval from St. Vincent's HREC (Study identifier: LNR/15/SVH/408) and Far North Queensland HREC (Study identifier: HREC/15/QCH/40-971) (See Appendix I).

These approvals were required to undertake non-participant observation in the mental health services.

I undertook non-participant observation in clinical environments that included inpatient settings and community centres. I received agreement through the Directors of the mental health services initially after presenting them with the proposed study and as mentioned above, the research proposal then went through ethical review at the local HRECs. Although ethnography has a long history of the covert study of occupation groups (Calvey, 2008), no actions were taken to keep my research secret from those I was observing. I introduced myself and my purpose for being there to the nurses who were working in the environments I visited, but I do believe beyond this group that others in those environments were not aware of my position or purpose in these spaces. They included allied health staff, medical team members and mental health consumers. This can raise an ethical concern about consent. This issue has been described in the literature on ethnography and research ethics, with authors noting the difficulty of ensuring everyone in the field is informed about the study (Green and Thorogood, 2004; Zavisca, 2007). Cognisant of this issue in fieldwork, I limited myself to staff environments such as offices and did not directly observe nursing care of consumers or interact with consumers in the practice setting. On an occasion that I found myself talking to a member of a medical team in an office space, I told them of my purpose for being there and explained the study in detail to them. As such, any individual who has contributed their narratives to the study during the fieldwork had all the relevant information to make a decision about talking to me (Pick, Berry, Gilbert, & McCaul, 2013).

Privacy and confidentiality are essential parts of the research process. Therefore I have had to ensure that the participants' identity remains confidential. All fieldnotes and interviews in the findings have anonymised so that participants or clinical areas have not been identified. References to individuals they have mentioned or the service they work in that may reveal the

identity of the participant were omitted from the findings. This was to ensure that the identities of the participants could not be linked to the information they supplied (Schneider et al., 2007). Although individuals familiar with the local health districts which have been the focus of the fieldwork may have an awareness of the services I would have collected the data in, I believe the approach I have taken would limit the potential of particular individuals to be identified.

4.5 Data Storage

Fieldnotes and interviewee consent forms were stored in lockable cabinets in the university. Transcribed interviews and audio-recordings were stored in a password secured folder on the university research server. These will be stored for at least seven years after the completion of this thesis. After this, data will be destroyed according to university and NHMRC guidelines.

4.6 Reflections on the research methods

The research design used in this study has provided a means to analyse a social phenomenon, an area of professional practice, which cannot be adequately accounted for by focusing on a single site. Therefore, the methods used were guided by the need to contextualise mental health nursing and its practice with Aboriginal and Torres Strait Islander users of public mental health services across multiple areas of practice. Collaboration with my supervisors, with my peers within the speciality of mental health nursing and later with the nurses with whom I connected over the course of the study, guided the development of the methods used in the inquiry, including the decisions about where to undertake observational fieldwork and key areas for data collection.

As a researcher, I cannot be removed from this research, in the sense I have influenced the data collection and the reporting of the finding (Pellet, 2003). It became essential for me as a researcher to reflect on this influence and understand its impact on the research (Emerson et al., 2011). This reflexivity has been an active process throughout this research and its write up. I have reflected on my own beliefs and ideas, my history and my cultural background, and the theoretical and professional perspectives I brought to the research and how they have impacted on the research process (Pellet, 2003). Undertaking reflexivity does not necessarily guarantee insight (Lynch, 2000), however in focusing on self in the research process it may promote 'a shift in our understanding of data and its collection' (Hertz, 1997, p. vii). In focusing on myself, I reflected on the potential impact my background as a mental health nurse had on my research. I was researching a professional group that I was a member of, so was, therefore, an insider (Angotti & Sennot, 2015). There were times when this background was useful, for example, it gave me understandings of clinical practice and mental health services. However, I had to question how these understanding and the assumptions that underlay them could restrict my research (Bourdieu & Wacquant, 1992). Both in my fieldnotes and supervision, I reflected on whether these professional assumptions could lead to bias in my research findings (Innes, 2009). Beyond the professional aspects of myself, I also spent much time focusing on my cultural background. As I noted earlier, I have struggled in coming to a country where I see settler colonialism celebrated. I have wondered at times, if this study has more to do with me trying to reconcile my guilt about the treatment of Aboriginal and Torres Strait Islander peoples in Australia, rather than about understanding and hopefully improving practice. Throughout this research, I have found this a challenging question to reflect. I feel passionate about improving mental health nursing practice with Aboriginal and Torres Strait Islander peoples and I do feel guilty about being a non-Indigenous person living on Aboriginal land because of the Indigenous experience of colonisation. Recruiting mental health nurses through the Australian College of Mental Health Nurses' Aboriginal and Torres Strait Islander Special Interest Group unexpectedly provided me with

access to an expert group of practitioners who had spent much time thinking about and trying to improve their practice with Aboriginal and Torres Strait Islander peoples. Their passion was obvious in the interviews, and they provided many details in regard their strong beliefs and ideas about this area of practice. These interviews provided me with insights into practice environments from across Australia from the perspective of practitioners who had much experience providing care to Aboriginal and Torres Strait Islander peoples in specialist roles. One of the issues with this group of interviewees was that they were so engaged with this area of practice that I questioned whether they were reflective of the wider speciality. Although I did not imagine I was creating a holistic description of the profession, I sought a wide range of perspectives. Later interviewees, recruited in fieldwork sites, had not established such overt and active interest in this area, and they brought variety to the narratives in the interview data, enriching the analysis.

I found observational fieldwork awkward at times. I would arrive into people's work lives with a notebook in my pocket and imagined myself a nuisance in the busy practice environments. After the initial interactions following my uncomfortable arrival, I found nurses were very quick to support the study. I believe my background as a mental health nurse helped to strengthen rapport with these nurses. I would tell them about my nursing background, describe the focus of the research, and they would talk in much detail about their perspectives of the care of Aboriginal and Torres Strait Islander peoples. This pattern continued throughout the fieldwork. Participants accompanied me around services, explaining processes of care and treatment and introducing me to their physical environments. Despite being many thousands of kilometres apart from each other, the services I studied were very similar in organisational structure, nursing management and in the general ambience of mental health nursing work environments. The experiences in these practice settings provided me with additional context beyond the narratives of the interviews and provided me with voluminous fieldnotes.

I was unsure how effective fieldwork would be at conferences when I first thought of using them within this research. Ordinarily, I am prone to shyness in such situations. Using these colloquia for data collection required me to seek out potentially useful informants about the topic of this study throughout the conferences. The organisation of a conference naturally lends itself to identifying such informants and having the space to interact with them. These gatherings also enabled me to have conversations with nurses from across Australia.

While I found the approach to data analysis strengthened the research, my choice in using grounded theory methods within an ethnography did expose me to methodological 'tribalism' (Pawson, 2001; Meyrick, 2006). This included those with a methodological background in grounded theory who questioned the application of the methods to an ethnography and ethnographers who questioned the use of grounded theory methods in an ethnography. A challenge for anyone undertaking ethnography is that there is no one accepted approach to data analysis (Hammersley & Atkinson, 2007). For this research, grounded theory methods enabled an approach to data analysis that was both systematic and co-ordinated. This was beneficial, particularly given the ongoing nature of fieldwork and the amount of data generated over the course of the research (Charmaz & Mitchell, 2001). I found the questions raised about the approach useful, in that they made me question my choice further and reflect on the application of the methods to the ethnography. They spurred me to read further about data analysis in ethnography and this made me feel confident in my choice.

4.7 Conclusion

In this chapter, I have explained how I constructed a multi-sited ethnography to explore the social realities of mental health nurses and contextualise the multi-sited social phenomenon of mental health nursing practice. This has been presented to provide the reader with an insight into both the plausibility and coherence of the finding in the chapters which follow. The insights gained from reflexivity, my understanding of the methodological framework and the findings from the data inform the concluding chapter of this thesis, where I discuss the finding and their implications for mental health nursing.

Chapter Five. Nursing care and Indigenous Australians: An autoethnography

5.1 Prologue

This published journal article presents an autoethnography related to my experiences working in an acute inpatient setting in an inner-city hospital. Throughout this study, I recorded fieldnotes both to document contextual information and to facilitate critical reflection on the research and my subjectivity as a researcher (Emerson, Fretz & Shaw, 2011). Amongst the fieldnotes, I followed the development of my interest in the research area. These writings led to the development of this paper.

Being a mental health nurse who has experience caring for Aboriginal and Torres Strait Islander people, this process of writing provided me with a means to focus on 'self' as 'site' of research within the multi-sited paradigm (Marcus, 1995). My clinical practice provided insights into the systems of care and treatment in an acute inpatient service. The writing to follow analyses this experience, connecting it with wider social meanings and understandings (Holt, 2003).

5.2 Publication

Molloy, L. (2017). Nursing care and Indigenous Australians: An autoethnography. *Collegian, 24*(5), 487-490.

Molloy, L., 2017. Nursing care and Indigenous Australians: An autoethnography, Collegian, 24(5), 487-490

5.3 Conclusion: Relevance for thesis

The published journal article presented in this chapter provides an analysis of my experience of public mental health services as they relate to the care and treatment of Aboriginal and Torres Strait Islander service users. Through critical reflections on the construction of practice, the manuscript highlights that *Western* knowledge in the form of biomedical models of nursing care and medical treatment were hegemonic in this public mental health service. This limited approach to practice undermines other possibilities of conceptualising experiences of ill health and alternative approaches to care and treatment. The situation ensured disadvantage for Aboriginal and Torres Strait Islander service users in relation to social and emotional wellbeing.

Chapter Six. More satisfying than factory work: An analysis of mental health nursing using a print media archive

6.1 Prologue

This published journal article presents findings from an analysis of mental health nursing using a print media archive. In my attempt to understand mental health nursing and its practice with Aboriginal and Torres Strait Islander peoples, I encountered a limited number of written resources in the typical sources of books, journal articles and government publications. A mental health nurse with interest in the study area, suggested newspapers as a possible source of information when I told her about the lack of scholarly and peer-reviewed literature. The possibility of this information compelled me to explore written sources including popular print media, such as local and national newspapers and magazines, in the hope of expanding my understanding of this area of practice.

The search of the National Library of Australia archive ultimately provided no information which connected mental health nursing with Aboriginal and Torres Strait Islander people. However, the stories that were uncovered provided a valuable insight into the past and present circumstances of mental health nursing.

6.2 More satisfying than factory work: An analysis of mental health nursing using a print media archive

Molloy, L., Lakeman, R., & Walker, K. (2016). More satisfying than factory work: An analysis of mental health nursing using a print media archive. *Issues in Mental Health Nursing*, *37*(8), 550-555.

6.3 Conclusion: Relevance for thesis

The publication presented in this chapter provided an analysis of some popular critiques by published commentators of the conjuncture mental health nursing finds itself in at the start of the 21st century. Historical sources showed that issues that have been viewed as developing in the last thirty years of significant change in nurse education in Australia had in fact troubled the speciality for many decades before them. The concerns expressed by contemporary writers are open to interpretation; however, there is clear communication about a speciality in crisis with its circumstances in recent literature related to mental health nursing.

I do not know what I expected to find in the newspapers, but that I found nothing related to mental health nursing and Aboriginal and Torres Strait Islander peoples is perhaps not surprising. The anthropologist, W.E.H. Stanner (1969) used a building analogy to describe how Aboriginal and Torres Strait Islander peoples had been omitted from the national narrative in Australia in the 20th Century. He stated 'It is a structural matter, a view from a window which has been carefully placed to exclude a whole quadrant of the landscape.' (Stanner, 1969, p. 25). Historical research on the history of care and treatment of mental illness in Australia barely mention Aboriginal and Torres Strait Islander peoples (Martyr 2011). However, the records of institutions highlight that Indigenous patients have been a feature of services right back to the earliest era of asylums (Finnane 2008, Martyr 2011, Armitage 2011). From the records that exist, we can surmise that mental health nursing care of Aboriginal and Torres Strait Islander peoples has been a regular practice for generations of Australian mental health nurses. However, what this practice was would seem to be lost in the pervasive forgetfulness that historically enveloped issues related to Aboriginal and Torres Strait Islander people (Stanner 1969).

Chapter Seven. Lip service: public mental health services and the care of Aboriginal and Torres Strait Islander peoples.

7.1 Prologue

This published journal article presents findings from the multi-sited ethnography of mental health nursing practice as it related to the care of Aboriginal and Torres Strait Islander people. It analyses the beliefs and ideas that nurses identified about public mental health services and the services they provided to Aboriginal and Torres Strait Islander peoples.

7.2 Lip service: public mental health services and the care of Aboriginal and Torres Strait Islander peoples.

Molloy, L., Walker, K., Lakeman, R., & Lees, D. (2018). Lip service: public mental health services and the care of Aboriginal and Torres Strait Islander peoples. *International Journal of Mental Health Nursing, 27*(3), 1118-1126.

7.3 Conclusion: Relevance for thesis

The publication presented in this chapter provides an analysis of institutional culture within mental health services. Mental health nurses practising in these services described their experiences of biomedical hegemony. While biomedical hegemony continues, attempts to improve service provision for Aboriginal and Torres Strait Islander peoples would seem superficial at best. These circumstances could explain why attempts to change service provision for Aboriginal and Torres Strait Islander peoples through government policy over the last two decades have failed to make an impact (National Aboriginal Health Strategy Working Party, 1989; Commonwealth of Australia 2004). The next chapter explores the potential for specialist mental health nursing practice with Aboriginal and Torres Strait Islander peoples within these circumstances.

Chapter Eight. Mental health nursing practice and Aboriginal and Torres Strait Islander peoples: A multi-sited ethnography

8.1 Prologue

This chapter presents findings from the multi-sited ethnography. The manuscript it presents explores specialist mental health nursing practice for Aboriginal and Torres Strait Islander peoples in public mental health services.

8.2 Mental health nursing practice and Aboriginal and Torres Strait Islander peoples: A multi-sited ethnography

This paper was submitted to the International Journal of Mental Health Nursing in December 2017 and is currently under review.

Mental health nursing practice and Aboriginal and Torres Strait Islander peoples: A multi-sited ethnography

Background

Public mental health services in Australia have been criticised for not addressing the cultural needs of Aboriginal and Torres Strait Islander peoples (McGough et al. 2018). Aboriginal and Torres Strait Islander peoples have also identified a general lack of respect when receiving treatment in these services (Nagel et al. 2012; Shepherd & Phillips 2016). There are even claims that health professionals work in exclusionary ways to the detriment and disadvantage of Aboriginal and Torres Strait Islander peoples (Walker & Sonn 2010).

According to a recent report, nurses constitute the majority of the professional workforce in these services (Australian Government 2013). Up until the 1970s, the nursing profession as a whole accepted segregation, then assimilation policies and their underlying paternalistic ideologies, incorporating the latter into their practice (Forsyth 2007). In relation to mental health services, it was not until the *Ways Forward* report in 1995, that any policy agenda was set for the mental health care of Aboriginal and Torres Strait Islander peoples. Since then Aboriginal and Torres Strait Islander peoples have become a key focus in Australia's mental health policy and planning (Commonwealth of Australia, 2017). These policy reforms have taken place within a wider context of the mental health system undergoing a sustained process of reform. The Australian Government is currently attempting to shape practice in mental health service provision through *The National Practice Standards for the Mental Health Workforce* (2013). These standards require that mental health nurses 'actively and respectfully reduce barriers to access, provide culturally secure systems of care, and

improve the social and emotional wellbeing and mental health of Aboriginal individuals, families and communities' (p. 14). More recently, the Nursing and Midwifery Board of Australia (2018) have identified that nurse must 'provide care that is holistic, free of bias and racism, challenges belief based upon assumption and is culturally safe and respectful for Aboriginal and/or Torres Strait Islander peoples' (p. 9). Culturally safe nursing care 'is about the person who is providing care reflecting on their own assumptions and culture in order to work in a genuine partnership with Aboriginal and Torres Strait Islander Peoples' (Nursing and Midwifery Board of Australia, 2018).

According to Nagel et al (2009), health professionals are poorly equipped to deal with the mental health needs of Aboriginal and Torres Strait Islander peoples. Health professionals, including mental health nurses, working with Indigenous communities have identified a lack of knowledge, skills and confidence to deal with the mental health needs of Indigenous service users (De Crespigny et al. 2006; Walker & Sonn 2010; Walker et al. 2014; McGough et al, 2018). Furthermore, there is a paucity of research-based, culturally derived models to support effective practice with Aboriginal and Torres Strait Islander peoples (Westerman 2010).

Methods

The aim of this paper is to explore the culture of mental health nursing practice in relation to the care of Aboriginal and Torres Strait Islander service users in public mental health services. The paper is a report from a study that aims to contribute to our understandings of current practices and attitudes to mental health nursing care for Aboriginal and Torres Strait Islander peoples and to describe in depth the current systems and processes within the Australian mental health services. A previous paper presented findings on public mental health

service provision and Aboriginal and Torres Strait Islander peoples (Molloy et al. in press). A future paper will present findings on mental health nurses' beliefs about Aboriginal and Torres Strait Islander peoples encountered in practice. This decision to prepare three manuscripts from the one study has been guided by the amount of data generated by the research process and the belief this will strengthen the reporting of our study.

The participants in this ethnographic inquiry, the professional group of mental health nurses, practise in many different clinical sites across diverse health services that constitute the Australian public mental health system. Undertaking an ethnographic study of this group enabled research on beliefs and social interactions within the group (Naidoo 2012). Using a traditional ethnographic approach could have potentially restricted this study to focus on a single site of practice. However, viewing the issues through the lens of multi-sited ethnography has enabled research that has explored mental health nursing culture across the country (Molloy et al. 2017).

The fieldwork that provided the data for this paper included nonparticipant observation in two health services: 1) a regional mental health service in Queensland; and 2) an inner-city mental health service in New South Wales. The sites where practice was observed included community mental health services, acute inpatient units and mental health teams working in emergency departments. In addition, seventeen mental health nurses were interviewed for between 30 and 70 minutes. Interviewees were recruited through the Australian College of Mental Health Nurses' 'Aboriginal & Torres Strait Islander Special Interest Group' e-list. Interested members were sent copies of the participant information sheet and consent forms via email. Interviews were carried out face-to-face with the majority of the nurses. However, interviews using phone and Skype were required were for five of the interviewees due to the distances required for a face-to-face interview. The interviews were recorded and later transcribed. A further twenty-eight nurses were informally interviewed within practice sites visited during fieldwork. All of

the informal interviewees were registered nurses who had experience providing care to Aboriginal and Torres Strait Islander peoples in public mental health services. Throughout the research process, the first author also maintained fieldnotes. These have contributed to the written record of the ethnography and acted as a method for reflexivity throughout the research itself.

The analytic strategy used for interview transcriptions and fieldnotes consisted of what Corbin and Strauss (2008) describe as open coding, axial coding, and selective coding. This inductive process produced the themes of this ethnography. Interview transcripts and fieldnotes were scrutinised line by line and words and phrases that conveyed meaning were labelled developing categories of information. The relationships between the categories were reviewed, enabling interconnections that existed between them to be identified. This allowed the identification of broader themes. The themes of 'biomedical creep' and 'lip service' provided the material for a previous paper (Molloy et al. in press), and the additional themes of 'mental health nursing and the Other' and 'respecting the difference' will be explored in a later paper. This article focuses on the following theme: 'a specialist practice'.

Data analysis revealed the interrelationships between practice experiences and ideas about practice. This provided a means of focusing observations on mental health nursing and its practice with Aboriginal and Torres Strait Islander peoples in public mental health services. The names used for all interviewees are pseudonyms. The study received ethical approval through the HREC (Tasmania) network (H0014330).

Findings

A specialist practice

Practice foundations

In conversations, many of the mental health nurse respondents were quick to highlight gaps in their foundational knowledge for practice with Aboriginal and Torres Strait Islander peoples. Otherwise confident practitioners lacked confidence in their care within this area. Health services provided their nurses with mandatory training in Indigenous health. While this allowed nurses insights into Indigenous Australian history, culture and health perspectives, what this actually meant for the provision of mental health care was unclear.

Interview

Coco: I personally have a knowledge deficit when it comes to that area I would say, in terms of how to provide really culturally sensitive, you know, mental health nursing or care to people.

Nurses described how their current knowledge deficits in relation to mental health care were compounded by the quality of learning experiences in undergraduate nursing education, where care for Aboriginal and Torres Strait Islander peoples was touched upon with minimal detail. Few could recall relevant content and many of those who did, highlighted how superficial they had found it. When visiting a regional acute inpatient unit, where the majority of those being cared for identified as Aboriginal, the first author talked to one of the nurses about his practice.

Fieldnotes

I ask him about his educational preparation to care for Aboriginal people and he laughs, "We watched [the film] Rabbit Proof Fence*, had a two-hour lecture but with nothing on mental health and went to a barbeque for NAIDOC week".*

Shannon described the knowledge she took away from her tertiary education that she deemed relevant to the area of care.

Interview

Shannon: I remember going through my university course and talking about the signs and symptoms and whatever of all different types of mental illness and then having this little thing attached to the end of it about cultural sensitivity. Cultural sensitivity contained some people like to be looked in the eye, some don't, some people like women, some don't. Shake their hand, some you don't. Different gestures mean different things to different cultures. So, there was this little adjunct.

For those nurses who had trained overseas, their practice with Aboriginal and Torres Strait Islander peoples was initially guided by their Australian co-workers. Reflecting on his own beginnings within an inpatient unit in an inner-city setting that served a large Aboriginal population, an Irish nurse noted the following:

Interview

Patrick: I got no orientation from Australian staff about 'This is what we do differently in Australia' [when nursing Aboriginal people].

Migrant nurses did not find a difference in the approaches to practice, but some found differences in attitudes to these service users. A British nurse described his experience in practice:

Interview

Joseph: When I first came over I didn't think, well, I have to be treating Aboriginal and Torres Strait Islander patients differently, that the treatment's going to be different. My first experiences I guess was I was aware of prejudices amongst some of the team that I worked with in my first job - I was working in an inpatient unit. So comments that you would hear related to the use of drugs and alcohol, related to them as their intelligence, not being particularly bright, kind of very stereotypical, you know, they didn't comply with treatment or they didn't want to engage with services, what did you expect, that's just what they're like, kind of thing. And so that was my first introduction.

Specialist practice

Nurses in this study did not believe that mental health nursing had developed a body of knowledge that could support specialist engagement focused on the unique mental health care needs of Aboriginal and Torres Strait Islander peoples. The actualities of how a specialist practice for an Indigenous Australian service user would be provided seemed nebulous.

Interview

Chloe: It means that we have mental health nursing care that we provide to people based, unfortunately still in some instances, on a medical model of care or even on a nursing paradigm of therapeutic relationships but we don't know what a therapeutic relationship looks like for Indigenous people. And we don't even know what is culturally appropriate for people around mental health and wellbeing that are Indigenous people …

One interviewee, reflecting on his own practice, said as follows:

Interview

Patrick: I don't have any particular knowledge about what Aboriginal sensitive care would look like.

Vic described how, in his role as a clinical nurse consultant in regional Victoria, restrictions in nursing knowledge had an impact on his practice:

Interview

Vic: If we're going into Aboriginal communities, which I do, I don't actually have any of the clinical resources to support my practice either.

With the limitations of knowledge to support a specialist practice for Aboriginal and Torres Strait Islander peoples, Joseph described his interpretation of how care for them was operationalised in his inner-city inpatient ward:

Interview

Joseph: There's no care plans written where that's identified, they don't get any different care while they're on the ward. The meetings all happen the same, like, the ward rounds all happen exactly the same. You don't hear people in clinical reviews talking about their cultural needs or anything specific.

Reflecting on her own experiences working in public mental health service, Shannon described a similar experience in these settings.

Interview

Shannon: My experience with the public system, I have to say, has been, I would say, from a day-to-day practice, I've not seen – was there a big difference in the way that I would have

treated an Aboriginal patient or a non-Aboriginal patient, and did I see that difference in my colleagues? I can't say there was.

Generic mental health nursing practice

Despite many of the nurses identifying an absence of specialist mental health nursing focused on the unique needs of Aboriginal and Torres Strait Islander service users, several nurses interviewed believed that generic practice skills that had been developed in mental health nursing could be relevant and effective.

Interview

Patrick: I can think of general principles in mental health nursing care that should lead to good care for people with Aboriginal backgrounds. And that notion of treating a person, getting to know the person – other than signs and symptoms …

Working in a regional emergency department, Tim provided the first point of mental health care for many Aboriginal and Torres Strait Islander peoples in the area. He described a key tenet of his approach to mental health nursing in relation to Indigenous presentations to his department.

Interview

Tim: Sometimes things are not actually that complicated and you can address, so a lot of the high prevalence kind of problems in Indigenous communities are just the same as the high prevalence kind of problems in other communities and can be addressed accordingly.

One of the sites visited during the study was a regional Australian community crisis team, where up to 50% of the people supported were Indigenous Australians. When discussing

approaches to care, a nurse viewed generic mental health nursing skills to be integral to their approach to nursing Indigenous Australians. Brenda told me the following:

Fieldnotes

Brenda: They don't give a damn, they're in crisis. So, it's about responding to that quickly.

However, the potential to default back to generic specialist mental health nursing practices was complicated by the evaluations of many nurses: that mental health nursing in Australia was not well-positioned to provide specialist mental health care more broadly.

Interview

Emily: We now have a situation where any Joe Bloggs, whatever, can turn up and work in a mental health setting.

In fieldwork, a Clinical Nurse Consultant questioned the quality of care in the inpatient mental health unit for Indigenous service users.

Fieldnotes

'Isabelle' questions the therapeutic skills of mental health nurses [working in the inpatient unit in regional Australia]. *They seem to her to be nurses who ended up in mental health, but don't have any specialist education.*

In the regional mental health service, a nurse manager described how her service found it increasingly difficult to get its registered nurses to do postgraduate studies in mental health nursing, as it was not part of their job requirements. Tim, who worked in another clinical site in this service as a clinical nurse consultant, described his beliefs about what impact this had on the nursing workforce in mental health.

Interview

Tim: They don't even nominally call themselves mental health nurses, they're not out there calling themselves anything, they're not represented by anybody or anything, and they're not mental health nurses and they have few psychotherapeutic skills.

Different practice

Despite the limitations on specialist knowledge and specialist-trained staff, over the course of the study, nurses were encountered who expressed confidence in their practice with Aboriginal and Torres Strait Islander peoples and articulated personal understandings that underpinned this confidence. For these nurses, this point had been reached after many years practising with Aboriginal and Torres Strait Islander peoples, in nursing positions with relatively high levels of professional autonomy, such as Clinical Nurse Consultant and Nurse Practitioner. Some had ultimately left the public mental health services to work independently in Aboriginal communities or work for private health providers. Shelley, a clinical nurse consultant who worked in the public mental health services, with a clinical load focused on Aboriginal mental health, described her approach to practice:

Interview

Shelly: I think it's respect. I honour - I honour the community. I really love the job I do, I really love it, and it's an honour to be accepted in the community as an Aboriginal health worker. So I think basically it's respect, it's about knowing, knowing your community, knowing who in the community are the gatekeepers if you want to use that word, like the elders in the community, and having their respect.

Chris, a Clinical Nurse Consultant in an inner-city inpatient unit, described her approach to practice:

Interview

Chris: I guess just to have respect and make that obvious. You know, to have respect for where they've come from, what they've been through, that I'm never going to understand that, not pretending I'm going to understand that and just giving some space for that. So respect would be the ultimate thing because I think that's something Aboriginal people don't feel they get from services so that's something we all need to do to make people feel more a bit comfortable being in here.

Working in a rural and remote South Australian context, Jessie described his approach to specialist mental health nursing care with a local Aboriginal community:

Interview

Jessie: It's such a different kettle of fish that we work into in the western world, completely different. So the care that I provide now is at complete odds with what I used to provide. I have to look at things in a very different way …

I do have to take very much into account about the cultural beliefs and the cultural systems. So I will often [do] what I didn't use to do so much of, you do a bit in the Western way, you collate the information, you go to relatives, you discuss it with them. And what I found now is you have to include family big time over here when you're working with Aboriginal or Torres Strait Islanders because my perspective may be completely slanted.

Discussion

Hellsten and Hineroa (2013) found that there are many challenges faced by mental health nurses caring for Aboriginal and Torres Strait Islander peoples in mental health services. One of these is that there is a dearth of knowledge related specifically to the area of mental health nursing and Aboriginal and Torres Strait Islander communities and their diversity of identities. Professional practice with Aboriginal and Torres Strait Islander peoples is influenced by the health professional's attitudes and understandings (Dudgeon & Pickett 2000). Given the clear gaps in mental health nursing's body of knowledge and an absence of guidance from Indigenous experts on what a specialist practice of mental health nursing would look like, it becomes unclear what understandings actually underpin such a practice.

Mental health nursing practice with Aboriginal and Torres Strait Islander peoples, as in any area of nursing practice, can be informed by a broad knowledge-base. This can include the history of Indigenous Australia, including the impact of colonisation (Goold 2001) and the role of the nursing profession in this history (Forsyth 2007); knowledge about trauma (Brown 2001; O'Brien 2005); racism (Trueman et al. 2011; O'Brien 2005); cultural competence (Goold 2001; Walker & Sonn 2010); cultural safety (McGough et al. 2017); as well as mental health approaches such as the ideas of recovery (Sayers et al. 2017), to name but a few. All these areas can be drawn upon to inform mental health nursing practice for Aboriginal and Torres Strait Islander peoples. However, how mental health nurses make choices from this broad knowledge-base, and the impact that these decisions has on practice with Aboriginal and Torres Strait Islander peoples was not clear during this research.

This study, which explored mental health nursing practice across many sites within Australia, found a disunited approach to practice in care for Aboriginal and Torres Strait Islander peoples. Practice was expressed as a series of individual constructions built upon the

nurses' beliefs about Aboriginal and Torres Strait Islander peoples and their experiences in practice with these peoples. Although guidelines on Aboriginal and Torres Strait Islander mental health exist (notably, Dudgeon, Milroy & Walker (Eds), 2014), this knowledge is aimed at the wider body of mental health professions and is not specific to mental health nursing practice per se. Mental health nursing knowledge is scattered across a few undergraduate book chapters and journal articles (some examples include De Crespigny et al. 2006; West & Usher 2011; Trueman 2013; Sambrano & Cox 2013; Durey et al. 2014; McGough et al. 2017).

In the absence of significant shared knowledge amongst nursing clinicians and health professionals about mental health nursing care and Aboriginal and Torres Strait Islander peoples and limited education around the area, the majority of nurses used the mental health nursing skills that were most comfortable to them and adapted them as needed. These circumstances created differing practice approaches between services and differing approaches within services. Further obscuring any picture of what nursing practice looks like in public mental health services is the presence of significant numbers of registered nurses with no specialist training in mental health nursing.

The requirements for mental health nurses to 'provide culturally secure systems of care' (Department of Health 2013, p. 14) would seem very difficult amidst the jumble of practice approaches that this study found to exist. It found no evidence of an effective and collective approach in the mental health nursing discipline to address this issue. The default action by public mental health services to achieve this, generic mandatory training related to the broad area of Indigenous health and health service needs, does not appear to evolve into informed specialist mental health practice for Aboriginal and Torres Strait Islander peoples.

The reasoning behind nurses maintaining generic approaches to mental health nursing was not articulated by the participants as an intention to exclude Aboriginal and Torres Strait Islander peoples or work in ways that they thought were detrimental or disadvantageous

to them. In both the interviews and informal conversations, nurses consistently expressed the desire to provide the best care they could for Aboriginal and Torres Strait Islander peoples. The issue for many of them was that they just did not know what that was or could— indeed, *should*—be. The criticism of mental health services from Indigenous communities was understandable to them, but how they could address this through their individual practices was unclear to them. In this context, they chose practice approaches that were guided by their personal interpretations of what had been effective in supporting people with mental illness in general when they encountered services that they found effectively met the care needs of the service user.

Conclusion

The Australian Government (2017) aims to shift, fundamentally, the way mental health services are provided to Aboriginal and Torres Strait Islander peoples. As the largest professional group working in public mental health services, nurses would seem essential to ensuring that change eventuates. As a speciality in nursing, mental health nursing has yet to develop a distinct approach to providing care for Indigenous service users. In the absence of developing practice cohesively as a professional group, practice approaches are individual constructions based on beliefs about Aboriginal and Torres Strait Islander peoples and the nurses' experiences in practice. This means Indigenous service users will encounter differences in practice between services and within services.

All service users accessing specialist mental health services should expect to receive care from specialist-trained mental health nurses. For Indigenous service users, that expectation should extend to receiving specialist care that is culturally safe and relevant to

them. Years of broad approaches at intervention, through individual cultural training (e.g. NSW Ministry of Health 2011) and broad focused frameworks (e.g. Commonwealth of Australia 2004), do not seem to have enabled the profession of mental health nursing to get any closer to providing this in any cohesive way. It is time for mental health nursing to take decisive action, or risk drifting further away from relevance in the care of Aboriginal and Torres Strait Islander peoples.

Implications for practice

Mental health nursing, it seems, is largely absent from the national strategy to improve mental health services for Aboriginal and Torres Strait Islander peoples. This is despite the prevalence of mental health nurses in services and the amount of contact they have with Aboriginal and Torres Strait Islander peoples in practice. Most recently, the Australian Government's *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* (2017) did not even identify nurses in its target audience, placing the focus on psychologists, allied health workers, psychiatrists, administrators and social workers. In many ways, nurses would seem lost in this practice space.

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8.3 Conclusion: Relevance for thesis

The manuscript presented in this chapter provides an analysis of mental health nursing practice as it relates to the care of Aboriginal and Torres Strait Islander peoples.

The speciality had not developed a clear knowledge base to support mental health nursing care for Aboriginal and Torres Strait Islander peoples, and there was no obvious shared approach to mental health nursing practice for these peoples. Practice was constructed from individual nurse's belief and ideas and shaped by their experience of working in mental health services. The next chapter will explore how mental health nurses' beliefs about Aboriginal and Torres Strait Islander services users shaped their practice.

Chapter Nine. Encounters with difference: Mental health nurses and Indigenous Australian users of public mental health

9.1 Prologue

This chapter presents findings from the multi-sited ethnography. The manuscript it presents explores mental health nurse's beliefs about Aboriginal and Torres Strait Islander peoples encountered in public mental health services.

9.2 Encounters with difference: Mental health nurses and Indigenous Australian users of public mental health

This paper was submitted to the Journal of Transcultural Nursing in May 2018 and is currently under review.

Encounters with difference: Mental health nurses and Indigenous Australian users of mental health services.

Background

Aboriginal and Torres Strait Islander peoples are the first inhabitants of Australia. Aboriginal peoples have historically lived on the mainland of Australia and in many of the country's offshore islands. While Torres Strait Islander peoples come from the islands of the Torres Strait, between the north of Australia and Papua New Guinea. Torres Strait Islanders are of Melanesian origin. According to the 2016 census, Indigenous Australians represent 2.8 per cent of the population of Australia, with 91 per cent being of Aboriginal origin, 5 per cent being of Torres Strait Islander origin, and 4.1 per cent reporting being of both Aboriginal and Torres Strait Islander origin (ABS, 2017). In this paper, we will use the term "Indigenous Australian" to describe both Aboriginal and Torres Strait Islander people.

After cardiovascular disorders, mental disorders have been reported to be the leading cause of disease burden among Indigenous Australians (AIHW, 2016). Between 2011 and 2013, the hospitalisation rate for Indigenous men with mental health issues was 2.1 times the rate for non-Indigenous men and Indigenous women with mental health issues was 1.5 times the rate for non-Indigenous women (AHMAC, 2017). The rate of suicide for Indigenous Australians is also reported to be 2.1 times the rate for non-Indigenous Australians (AHMAC, 2017).

To have some understanding of the contemporary experiences of Indigenous Australians, historical background is essential (Dudgeon, 2014). At the onset of colonization from 1788, Indigenous communities were subjected to a violent and unremitting invasion (Broome, 2010). As the invasion gradually engulfed Australia, the settler's claims to the land

overrode the Indigenous Australian people's right to life (Reynolds, 2013). The initial period of colonization, which also saw the devastating impact of introduced diseases, such as smallpox and influenza, was characterized by 'no overarching policies, but rather piecemeal, missionary-inspired approaches within a general climate of neglect and "elimination'' (Eckermann et al., 2010, p 21).

From 1837 onwards, there was establishment of a number of "Protection Boards" whose main role appeared to be the prevention of the spread of contagious diseases to non-Indigenous people (Kidd, 2005). Legislation also empowered these boards to remove children from their families for a variety of rationales, including health (HREOC, 1997). The seizure of children would continue even as government policies towards Indigenous Australians changed and between 1910 and 1970, it is estimated that somewhere between one in three and one in ten Aboriginal children were forcibly taken from their families (HREOC, 1997).

From the 1890s, the non-Indigenous community attempted to systematically segregate itself from the surviving Indigenous population. Under the guise of protection, Christian missions and government reserves were established throughout the country. From the 1950s, the Australian government introduced policy focused on the idea of assimilating the Indigenous communities into non-Indigenous society. The government stated that:

"All Aborigines and part Aborigines are expected to eventually attain the same manner of living as other Australians…enjoying the same responsibility deserving the same customs and influenced by the same beliefs, hopes and loyalties as other Australians"

(Hasluck, 1961, p 1)

The policy was premised on the belief that the only way to achieve a harmonious coexistence in Australia between the Indigenous and non-Indigenous communities was by breeding out Aboriginality (Saggers & Gray, 1991).

As Indigenous Australians became increasingly politically active in the 1960s, the demand for self-determination increased. By 1973, the Federal government recognised Aboriginal people as a distinct cultural group in Australia and identified that they deserved the opportunity to determine their own future (Eckermann et al., 2010). The Commonwealth Office of Aboriginal Affairs was established and identified health as a key area for development and commenced grants to the States to enable the development of special health programs. Government Ministers also endorsed a National Aboriginal Health Strategy (1989) against a back drop of sparse, but damning, health statistics (Eckermann et al., 2010).

In relation to mental health services, it was not until the *Ways Forward* report in 1995, that any policy agenda was set for the mental health care of Indigenous Australians. Since then Indigenous Australians have become a key focus in Australia's mental health policy and planning (Commonwealth of Australia, 2017). These policy reforms have taken place within a wider context of the mental health system undergoing a sustained process of reform.Since the 1995 *Ways Forward* report, it has been increasingly recognised in government policy that mental health and well-being are intrinsically connected to the 'whole of life' for Indigenous Australians (Swan & Raphael, 1995, p. 20). After the publication of *Ways Forward*, policy related to mental health has focused on social and emotional wellbeing, described as "a multidimensional concept of health that includes mental health, but which also encompasses domains of health and wellbeing such as connection to land or 'country', culture, spirituality, ancestry, family and community" (Gee et al., 2014, p. 55).

State-provided public mental health services include community-based and inpatient services, and these are often the only mental health services available to Aboriginal and Torres Strait Islander peoples (Isaacs et al., 2010). Aboriginal and Torres Strait Islander people have identified a lack of respect for their culture behind negative health care experiences in public mental health services (Walker et al 2014). These services have been criticised for not

addressing the cultural needs of Aboriginal and Torres Strait Islander peoples (McGough et al., 2017). There are even claims that health professionals work in exclusionary ways to the detriment of Indigenous service users (Walker & Sonn, 2010).

Nurses represent the largest professional group practising in these services (Government of Australia 2013). Challenged by the above critique, the authors undertook an ethnography of mental health nursing practice as it relates to Aboriginal and Torres Strait Islander mental health service users.

Methods

The aim of this ethnography was to explore the culture of mental health nursing as it related to the care of Aboriginal and Torres Strait Islander service users in public mental health services. The study aimed to contribute to our understandings of current practices and attitudes, and to develop an in-depth description of current systems and processes within the Australian mental health services. Two previous papers from the ethnography have focused on findings regarding specialist mental health nursing practice and public mental health service provision. This paper focuses on mental health nurses' beliefs about their Aboriginal and Torres Strait Islander peoples encounter in practice. The decision to present finding over three papers has been guided by the amount of data generated by the research process and the belief that it will strengthen the reporting of our study.

Mental health nurses in Australia practice across a variety of clinical sites within multiple health services. Using a multi-sited ethnographic approach allowed the research to explore the culture of a group of professionals across the country (Molloy et al 2017). Materials for the ethnography were collected between October 2014 and December 2016 by the primary

author. The fieldwork for the study included participant observation at two mental health nursing conferences and nonparticipant observation in two district mental health services. The sites where practice was observed included community mental health teams, inpatient wards and mental health teams working within emergency departments.

In-depth interviews were also conducted with 17 mental health nurses from across the country, recruited through the Australian College of Mental Health Nurses' 'Aboriginal & Torres Strait Islander Special Interest Group' e-list and within the fieldwork sites. These interviews lasted between 30 and 70 minutes and were recorded and transcribed for data analysis. A further 28 mental health nurses were engaged in conversations in site visits. Fieldnotes were recorded at the end of each interaction. All nurses interviewed were registered nurses who had experience practicing in the public mental health services.

Over the period of the research, we undertook a review of relevant documents including scholarly literature, professional and health service documents, government publications and historical documents related to the speciality. Throughout the research, the primary author undertook fieldnotes accumulating a written record of the ethnography and as a method for practicing reflexivity throughout the research process itself.

The analytic strategy used for interview transcriptions and fieldnotes followed what Corbin and Strauss (2008) describe as open coding, axial coding, and selective coding. This inductive process derived the themes of this ethnography explored in this article, namely "mental health nursing and the Other" and "respecting the difference". The other themes, "biomedical creep" and "lip service" and "a specialist practice" have been explored in two previous papers (Molloy, 2017). The names used for all interviewees are pseudonyms. The study received ethical approval through the HREC (Tasmania) network (H0014330).

Findings

Mental health nursing and the Other

Throughout this research a repeating element in mental health nurse's conversation about Aboriginal and Torres Strait Islander people was a focus on ideas of *otherness*. This included descriptions of alterity they had found in practice and how their ideas of *otherness* influenced their mental health nursing care. Nurses both positioned themselves, and believed themselves to be positioned, as different from Indigenous Australians.

Interview

Jim: Number one was I was a 'white fella' and I was never going to be an Aboriginal person.

Interview

Patrick: It seems to be binary, one or the other. You're one of them or you're one of us. You can't be we.

In the practice setting, a divergence between non-Indigenous and Indigenous service users was identified within ideas about Indigenous Australians having more complex presentations. One nurse working in regional Victoria described his ideas about the Indigenous Australian service users he had encountered, as follows:

Interview

Vic: Issues of trauma, substance use, difficulties in engagement would be key things, and getting a good flow of treatment happening on a regular basis have been some of the challenges. I've certainly had challenges because I've had some pretty chaotic clients in the past and frequent admissions and relapse because of all of those issues I just mentioned.

In saying that, I've also had some fairly straightforward cases as well, but probably on balance maybe the people that are more disabled or impaired by their illness come to the attention of the public mental health system, and those that are able to get by, maybe they stay away from mainstream services, and so you don't get that same range of people that you might get in non-Indigenous people that attend a mental health service.

Joseph, a Clinical Nurse Consultant, working in an inner city inpatient unit, reflected on how his expectations that an Indigenous person would present differently from non-Indigenous people using his service, could influence his clinical judgement and impact on his practice.

Interview

Joseph: We've got a young girl at the moment, she's Aboriginal and she looks absolutely like, she's walking around the ward like, someone's just clobbered her in the head with something. She had this punch-drunk kind of shell shocked look about her. And I didn't stop to talk to her or even spoke to the staff about her or anything. I'm just aware that when I see that I don't think it's that unusual, you know, in terms of like, she's probably got head injuries or she's probably got alcohol damage, you know, I just think – I don't even have those conscious thoughts as I'm trying to make sense of when I see her, it's almost like, okay, just walk off.

Whereas if I saw a white female, early twenties looking like that, would I be more inclined to think, bloody hell, what's wrong with her and stop and take the time and go check, what's the story, what's going on?

Nurses noted alterity in relation to the "mental illnesses" which had brought Indigenous Australian people to the mental health services. These experiences seemed to set them apart from those generally seen in practice. Nurses used words like 'unbelievable' 'different' and 'amazing' to describe them. Their stories articulated how what was observed did not fit within their *Western* understandings of mental illness and nurses seemed uncomfortable to label them as this. Sharing a story from his time in remote Western Australia, Jim described the following:

Interview

Jim: There was a really amazing example of a guy who was diagnosed as schizophrenic. He had been on anti-psychotic medication for about three weeks before he was being specialled because he became suicidal. The health worker knew a healer from [an Aboriginal community] and he was going to visit that night. The [Aboriginal] health worker heard the healer tell him to leave the toilet seat open because there needed to be water close by and that was the only water close by.

The next morning, we were doing the rounds. There happened to be a psychiatrist in and we went to see and this guy was 'un-psychotic', he was fine. Not suicidal and when we asked him he said the spirit came and he took certain twigs from his head and chest and stomach and he said he took them out and that was it all the evil spirits had gone. Whatever the reasoning was, within a week that guy was back in [an Aboriginal community]. The psychiatrist said it was the medication. That it just happened. But as a matter of fact, in this guy's mind it was the

healer that caused it. It's like telling a ghost story. It loses its impact. But being there. It had a huge impact on me. This man was affected by his traditional healer.

Such experiences could shape mental health nursing practice to address Indigenous understandings rather than psychiatric ones. Working in remote South Australia, Jessie described how after encountering an Aboriginal man who reported that a snake would come out of his mouth every night, he was advised to adapt his assessment by colleagues. He explained:

Interview

Jessie: I had to check out what type of snake it was because that has significance.

The boundaries between difference and similarities were confusing for nurses. Nurses accepted that hearing voices could be culturally appropriate at times, but on other occasions believed what they were seeing was psychotic illness. Shannon related an issue from her service in an urban area, as follows:

Interview

Shannon: It messes with your brain. I remember this one particular patient that sticks in my mind. He was, as far as I was concerned, actually psychotic. He was saying he was hearing the voice of his dead uncle. We could call in this Aboriginal elder that used to come and work, and she was adamant that this was culturally appropriate. But there were times when the team were thinking we need to [administer a sedative anti-psychotic to] this man. He's dangerous to himself. It's that real rub about being sensitive but being – hang on, I'm a mental health nurse. This looks psychotic to me. That gentlemen who I'm talking about actually committed suicide. That was, to me, my shifting point … It's a balance to me, and I have to take what's presented in front of me, and I've learnt to trust my instincts.

Respecting the difference

For some of the nurses, the very idea of difference, be it acknowledging difference or treating an Indigenous Australian user of a mental health service differently made them uncomfortable. The reasons behind this varied between nurses. A key concern for some nurses was that highlighting difference could be construed as discriminating against someone. For example, describing her practice in an inner city community health service, Mystique, explained:

Interview

Mystique: Upon assessing someone or getting a call on the triage line, you have to ask, 'Are you of Aboriginal or Torres Strait Islander?', I just don't think that's really necessary. It just doesn't seem right. And it just causes such a divide when you're just always singling out a group of people that have always been singled out and it adds to that stigma.

Many nurses expressed a strong belief in an ideology of treating Indigenous Australians 'the same'. The related nursing care seemed to have a fixed approach to all service users regardless of their cultural background, which nurses saw as fair and just. Treating people differently had the potential to corrupt these principles. While excluding someone from this sameness of practice could potentially be viewed as unfair and unjust. A nurse working in a rural setting stated:

Interview

Annie: I believe in treating [Indigenous Australians] the same as everyone else.

Patrick linked his ideas to a belief in wider professional expectation for equality in nursing care, deviation from which could be viewed as racism:

Interview

Patrick: I think there's a conflict with 'everyone should be treated equally' and to make an exception for someone who's Aboriginal … How do you balance being nuanced and culturally appropriate to somebody but not treating them differently because of their race, which is proven to be construed as almost racist?

Two nurses engaged in conversations in inpatient settings vehemently opposed engaging Indigenous cultural differences in the practice setting. In talking to a nurse about the mandatory cultural training program, Respecting the Difference (NSW Ministry of Health, 2011). I noted:

Fieldnotes

He believes that Aboriginal and Torres Strait Islander people should do courses about how they should integrate with 'mainstream culture. What is this culture? White culture? I'm not white'. He didn't find that mandatory training told him anything new. He doesn't believe in treating people differently.

While a Clinical Nurse Consultant was concerned about the direction of service delivery in his area. I noted:

Fieldnotes

James believed that treating Aboriginal people differently would only lead to a sense of entitlement and a limited engagement with services.

Nurses who seemed less challenged by the idea of the potential for differing approaches to care needs due to cultural differences constructed practice as responding to an individual's or community's need.

Interview

Eve: Its like friends … I treat them the same but maybe I have different relationships with different people, and the [Aboriginal] clients are the same.

Fieldnotes

Georgina wonders how we can talk about a concept like recovery, without acknowledging difference. She notes the need to be different with different groups in her service.

For Shelley, a Clinical Nurse Consultant working with a local urbanised Aboriginal community, her idea of the Indigenous Australian service user was not simply viewing them as an individual, but viewing that person 'as a community'.

Discussion

All the nurses interviewed over the course of this research identified as non-Indigenous Australians. The study therefore represents an ethnographic analysis of a group of non-Indigenous mental health nurses in regards to their practice with Indigenous Australians. This, of course, is a clear limitation, presenting only a few voices in a multivocal story. However, given the relative silence on this issue amongst this group more broadly, we believe it to be important to add these findings to our understandings of relationships that are complex

and interconnected (Marcus & Fischer, 1996). Prakash (1995) notes that colonialism has "instituted enduring hierarchies of subjects and knowledges –the colonizer and the colonized, the Occidental and the Oriental, the civilized and the primitive, the scientific and the superstitious, the developed and the underdeveloped". These divisions are not just historical, but continue to influence contemporary discourse in postcolonial societies (Prakash, 1995). Nurses described their experiences within these hierarchies, where there was a near absence of any focus on Indigenous Australian culture in their earlier lives. Vic described his own experience, as follows:

Interview

Vic: We had nothing – nothing in terms of education. The best we got back at that school was kids brought in Aboriginal artefacts like boomerangs and spears and things, and we all thought that was cool as primary school kids. Wow, let's have a go at that boomerang, but never understood anything about the culture or where they'd all come from. Through my high school years, nothing. History was all about White Australia, and the world wars were all we learnt about.

Few of the nurses described any significant contact with Indigenous Australian people prior to entering nursing. Therefore, practice experiences in mental health services brought the longest and most sustained contact many of the nurses had with Indigenous Australians or their cultural beliefs. Perceptions of the legacy of colonialism continued to influence nurses in their discomfort in emphasising difference, fearing it mirrored the overt segregation practices of *white* Australia.

For some decades, Indigenous Australian constructions of Indigeneity have involved elements of boundary construction between Indigenous and non-Indigenous identities (Paradies, 2006). Lock (2007) notes Indigenous Australian health discourse has promoted ideas

that holism is immutably Aboriginal and antithetical to *Western* culture. Over the last two decades there has been a gradual push to improve cultural awareness related to Indigenous Australian people in mental health service. For most nurses encountered during the study, the differences articulated about Indigenous Australian people was not clearly described within any obvious differing conceptualisation of mental health. Difference was for the most part, related to behaviour observed within care, not through concepts related to social and emotional wellbeing. While most nurses talked about the importance of family and communities, and a few nurses mentioned connection to land, there was little clearly expressed about spirituality and ancestry, beyond the potential to hear the voices of ancestors. The understanding of the concept of social and emotional well-being would still seem not to have progressed much beyond the phrase itself and some understanding of the basic definition for many mental health nurses.

Colonization and its intergenerational impact continues to have a massively disproportionate impact on the health of Indigenous Australians (Hollinsworth, 2013). One of the consequences of this from the perspective of mental health nurses is Indigenous Australian users of mental health service are not simply viewed as different from non-Indigenous service users due to their cultural background, but also due to the level of ill-health they present with in mental health services. Mental health services, tragically, provide a window into the ongoing impact that colonization has on Indigenous Australians and mental health nurses are witness to this regularly.

In the context of the mental health services in Australia today, the mental health nurses encountered during this study described their beliefs about a dichotomy between “us” and “them”, when discussing Indigenous Australian service users. These circumstances created ideas about a separation between nurses and Indigenous Australian service users that went beyond those traditional conceptions of the power division between mental health staff and

service users (Goffman, 1968). Describing his experience in an inner city mental health service, one nurse noted:

Interview

Joseph: I think it's just an extra layer with the Indigenous patients in that not only are we judgmental but we also have that more of a disconnect from them so it's harder to gain that, probably less effort to get a rapport with them, you don't identify.

The ongoing impact of colonization on the health of Indigenous Australians and the perceptions of a cultural difference would seem key drivers in this.

Nurses navigated their ideas of alterity in very individual ways. Most were actively trying to learn about Indigenous people and their culture, and attempting to understand what this meant for them as health professionals. There were also others disrespectful of difference and clearly hostile to addressing different needs in practice. The variations of opinions encountered during the study reflected that there was no unified approach to engage with or accommodate Indigenous cultural needs in mental health nursing practice in Australia. Nursing approaches seemed to be guided by personal beliefs about mental health nursing and Aboriginal and Torres Strait Islander peoples, rather than guided by a shared professional knowledge on practice with these service users.

A significant challenge that nurses identified was related to their ability to identify behaviour as culturally appropriate or as a symptom of ill health. This was particularly urgent when people were acting in ways that put them at risk to themselves. Nurses relied on members of the Indigenous community to guide them on this. However, throughout the fieldwork nurses identified a paucity of trained Indigenous staff working in mental health services. Nurses in

both health services highlighted the need for greater numbers of Indigenous mental health nurses to support Indigenous service users and guide them in their practice.

Conclusion

For people who work in public mental health services, a challenge in promoting recovery is to provide services that adequately meet the needs of Indigenous Australians. Within these services, culturally valid understanding must shape a mental health practice (Australian Government, 2017). Mental health nurses are required to 'actively and respectfully reduce barriers to access, provide culturally secure systems of care, and improve the social and emotional wellbeing and mental health of Aboriginal individuals, families and communities' (Department of Health, 2013, p. 14).

The research found that 'culturally secure systems of care' are not an obvious feature of the mental health nursing care of Indigenous Australians. Care approaches would seem fragmented and constructed by individual practitioners, based on their own ideas about what form the care should be. The Indigenous concepts of social and emotional wellbeing would seem to remain lower in the hierarchy of knowledge against Western understanding of mental health.

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9.3 Conclusion: Relevance for thesis

The manuscript presented in this chapter provides an analysis of mental health nurses beliefs and ideas about Aboriginal and Torres Strait Islander peoples encountered over the course of this research. The Aboriginal and Torres Strait Islander service user was positioned as *Other* to the non-Indigenous mental health nurse, and to other non-Indigenous service users. Despite emphasising the differences with Aboriginal and Torres Strait Islander peoples in mental health services, mental health nurses did not clearly relate this to Indigenous ways of understanding ill-health using the concept of social and emotional wellbeing. While cultural differences were recognised, what they meant for the nurses or their nursing practice was interpreted in different ways.

Chapter 10. Conclusion

10.1 Introduction

This chapter reviews the aims and research question that were the focus of this multi-sited ethnography of mental health nursing in relation to the care of Aboriginal and Torres Strait Islander users of public mental health services. It considers whether the study achieved its aims and outlines how it answered the research question. My empirical chapters have all been presented in the form of published journal articles and manuscripts that include conclusions on the findings. In order to avoid excessive repetition, I will summarise the key finding as they relate to my research question. This will be followed by discussion of implications of the research findings for mental health nursing and public mental health services. The chapter concludes with a discussion of limitations of the study and suggestions for future research.

10.2 Review of aims and research questions

In Chapter 1, I stated my aim for this study. This was to undertake an ethnographic analysis of the culture of mental health nursing in relation to its practice with Aboriginal and Torres Strait Islander users of public mental health services. I believed that a multi-sited ethnography could develop an in-depth description of current systems and processes within Australia's public mental health services and contribute to understandings of current practices and attitudes. I noted that these understandings could identify where improvements in the delivery of mental health nursing could be focused. The specific research question that I followed from the start

of the research was: *What beliefs do mental health nurses have about nursing care and Aboriginal and Torres Strait Islander peoples in public mental health services, and how are these expressed in practice?*

10.3 Addressing the research question

There is a dearth of literature, including published research, which explores mental health nursing and its practice with Aboriginal and Torres Strait Islander peoples. This study has contributed to redressing this gap. The ethnography employed observational fieldwork and explored the beliefs of a group of mental health nurses recruited for in-depth interviews and encountered in fieldwork.

Mental health nurses discussed the concept of a constricting medical/biomedical 'model' of mental illness in public mental health services. This was an issue raised by nurses in rural community services, regional towns, capital cities and in remote Indigenous communities. The hegemony of the biomedical paradigm was one factor that restricted nurses' abilities to provide authentic holistic care focused on social and emotional well-being to Indigenous users of public mental health services. Nurses believed that institutional interventions and government policies to improve the circumstance for Indigenous Australian users of public mental health services had a negligible effect on service provision. The mental health service was a place where *white* privilege was maintained by the dominance of biomedical approaches to care and treatment.

Mental health nurses felt alienated from their services and questioned the quality of mental health service provision for all service users, but particularly Aboriginal and Torres Strait Islander service users. They believed they understood why there were criticisms of the public mental health provided to Aboriginal and Torres Strait Islander peoples. Despite this alienation,

there was no obvious active resistance observed or described. The group appeared unable to change their services and the mental health nurses believed that, in many cases, nurses actually maintained the biomedical hegemony to the detriment of Aboriginal and Torres Strait Islander service users.

For those nurses who had undertaken specialist mental health nursing training, there was a belief that many of their colleagues in mental health nursing had no specialist skills to provide mental health care. Overseas-trained nurses described the need to 'de-skill' to work in the Australian public mental health services as nurses. The workforce encountered in fieldwork was far from a homogenous group of trained specialist nurses. Many nurses practiced with only an undergraduate comprehensive nursing education. A sense of strong specialist identity was found in individual practitioners, who consistently reported the erosion of mental health nursing as a speciality. The limited amount of mental health content in undergraduate nursing courses and the failure of many nurses to engage in postgraduate mental health nursing education were singled out as the key contributing factors for this situation.

This study did not find any significant body of knowledge related to the mental health nursing care of Indigenous Australians. Nor did it find a unified approach to practice in care for Aboriginal and Torres Strait Islander peoples. Practice was expressed as a series of individual constructions built upon the nurses' beliefs about Aboriginal and Torres Strait Islander peoples and their experiences working with these peoples in largely institutional settings. The majority of nurses used the skills of mental health nursing that they were most comfortable with, and adapted them as needed. Beliefs about mental health nursing practice and Aboriginal and Torres Strait Islander peoples was found to vary within services and between services.

The reasoning behind nurses maintaining their current approaches to mental health nursing was not described in terms of having the intention of excluding Aboriginal and Torres Strait Islander peoples or working in ways that they thought were disadvantageous to them. However,

in not addressing social and emotional wellbeing within their practice with Aboriginal and Torres Strait Islander users of public mental health services, nurses risked these outcomes from their care (Walker et al 2014). Nurses regularly described their desire to provide the best care they could for Aboriginal and Torres Strait Islander peoples. The issue for many of them was that they just did not know what form that practice would take. Nurses positioned themselves and felt positioned as 'other' to the Indigenous Australian service user. Perceptions of cultural difference and the legacy of colonisation, including its impact on the health of Aboriginal and Torres Strait Islander service users were key factors behind their beliefs in Aboriginal and Torres Strait Islander peoples alterity. Over the course of the research, it became apparent that most of the mental health nurses encounter during fieldwork did not have a clear understanding of the concept of social and emotional wellbeing, despite it being key to the Australian government's attempts to promote positive services for Aboriginal and Torres Strait Islander peoples for many years (Australian Health Ministers' Advisory Council, 2004). The concept did not define the ways mental health nurses viewed the Aboriginal and Torres Strait Islander people they were caring for, or the situations in which they presented themselves to services. Mental health nurses recognised differences in Aboriginal and Torres Strait Islander service users, but what this difference meant for nursing practice was interpreted individually by mental health nurses. The findings of this study go beyond the current knowledge base on this area by providing new insights into the current practices and attitudes of a group of mental health nurses from various sites of practice across Australia about practice with Aboriginal and Torres Strait Islander peoples. The findings have also provide in-depth descriptions of current systems and processes of care and treatment within Australia's public mental health services. They have presented an analysis focused on the beliefs of mental health nurses in relation to their practice and the care they provided to Aboriginal and Torres Strait Islander peoples in public mental health services.

10.4 Implications for mental health nursing

While engaging in this ethnographic study of mental health nursing, I encountered a professional group for whom the actualities of being a 'speciality' within nursing would seem to be increasingly tenuous. Specialist training is not a prerequisite for practice in the speciality. The level of knowledge around mental health nursing appeared variable across the sites observed in practice and the lack of specialist skills amongst nurses was an issue regularly identified by interviewees. Issues of professional ambiguity have troubled mental health nurses for decades, particularly given the complex nature of their work (Hercelinskyj, Cruickshank, Brown, & Phillips, 2014). However, the ambiguity encountered during this research was less about the intricacies of role and its function and more about nursing's fitness for purpose in the domain of specialist mental health care (Browne, Hurley & Lakeman, 2014).

Psychiatry is clearly the most powerful professional group in public mental health services and mental health nursing is significantly enmeshed with it (Barker & Buchanan-Barker, 2011). As biologically-focused approaches to psychiatry have become increasingly dominant over the last three decades (Deacon, 2013), there have been significant reverberations for mental health nursing in Australia. Long-serving mental health nurses described the loss of multi-dimensional approaches to nursing care and mental health service provision. With services increasingly focused on biological interventions, nursing care has become overtly focused on giving out psychotropic drugs, watching for their effects and monitoring and managing the significant physical health impacts of chemical substances used in interventions. Comprehensively trained nurses with no specialist training easily default to this approach to practice. The findings provide further details about how the comprehensive model of nursing education continues to fail to meet nursing workforce needs within mental health services in Australia (Happel & McAllister, 2015).

The current circumstances of mental health nursing care for Aboriginal and Torres Strait Islander peoples encountered in this study were complicated. The ideas expressed about practice were varied and disunited. There is no robust body of knowledge to support practice despite decades of criticism and there is nothing resembling a cohesive approach to care in this area. Mental health nursing seems no closer to creating the circumstance that could potentially address concerns about inappropriate care and would seem simply to have reached the point where it acknowledges and accepts them, reports feeling badly about them, but makes no attempts to evolve its practice to address them. Over a decade ago, Henry, Houston, and Mooney (2004) identified that mainstream health services make almost no effort to provide culturally secure services for Aboriginal and Torres Strait Islander peoples. The findings highlight how the current construction of mental health nursing practice for Aboriginal and Torres Strait Islander people remains one of the key barriers to providing mental health services that are culturally secure to Aboriginal and Torres Strait Islander peoples and that there is no obvious collective effort being undertaken within the speciality of mental health nursing to change this.

Racism is acknowledged to undermine the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples, and redressing racism direct towards Aboriginal and Torres Strait Islander peoples has been identified as a national priority in Australia (Priest et al., 2011). The research findings highlight that mental health nurses identified discrimination towards Aboriginal and Torres Strait Islander to be an issue both in mental health services and within their speciality. This issue has festered within mental health nursing despite the attempts of professional regulators to expunge discrimination from nursing through standard setting (Nursing and Midwifery Board of Australia, 2010). While recent changes have attempted to be more specific to the care of Aboriginal and Torres Strait Islander peoples (Nursing and Midwifery Board of Australia, 2018a), the research findings would suggest that standards alone

are not sufficient in eradicating discrimination in nursing.

Durey (2010) has highlighted the importance of preparing undergraduate students in health professional courses for culturally respectful health care within their education programs, as a means for confronting racism and promoting long-term improvements in practice. While in recent years, there has been a commitment to include Aboriginal and Torres Strait Islander peoples' health and cultural issues in courses leading to registration (Australian Nursing and Midwifery Council, 2007), few of the nurses' encountered during this research had received undergraduate education on the area. While the recent changes should be welcomed, it would seem for many nurses their understanding for practice has been informed by short work-based training courses that do not have a specific focus on nursing care or mental health services. Combined with the limited evidence-base related to mental health nursing and Aboriginal and Torres Strait Islander peoples, the foundations for practice improvement in this area would seem to be weak at best. The prospect of improving practice through undergraduate education pushes the prospect for effecting change off by many years when the need for action now is clear (Commonwealth of Australia, 2017).

The research findings highlight the clear need to involve Indigenous communities in the review of mental health nursing practice in Australia. A solution proposed by the Australian Government in the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (Commonwealth of Australia, 2017) highlights the need for partnership and dialogue with communities around what approaches to care and treatment would best meet their need. This would seem to be one approach mental health nursing could utilise to address the ongoing criticisms of the appropriateness of care and aid the development of the body of knowledge that can guide specialist practice with Aboriginal and Torres Strait Islander peoples. Increasing Indigenous recruitment into mental health nursing should also be a priority for the speciality as these nurses

can bring unique skills, knowledge and understanding to health service delivery for Aboriginal and Torres Strait Islander peoples (West, 2010).

10.5 Implications for mental health services

The research findings provide clear insights into the need for reformation of public mental health services to provide adequate and meaningful services for Aboriginal and Torres Strait Islander service users, as well as mental health service users more broadly. The challenge for mental health service in ensuring reconciliation and recovery is to provide care and treatment that adequately meet the needs of Aboriginal and Torres Strait Islander peoples (McGough et al., 2018). Within these services, culturally valid understanding must not only shape individuals' practice but also provide the basis of all health services approaches for Aboriginal and Torres Strait Islander peoples (Commonwealth of Australia, 2017). The medically biased biological approach to care and treatment described by interviewees and revealed by nurses in observational fieldwork appears to have no flexibility to embed concepts such as social and emotional wellbeing and their implications for practice. The dominance of the medically biased biological perspective on mental illness excludes Aboriginal and Torres Strait Islander perspectives on health in public mental health services and it is difficult to imagine how culturally appropriate recovery-orientated services could be delivered in such circumstances.

Staff could clearly identify approaches that their own mental health services were undertaking to address the mental health needs of Aboriginal and Torres Strait Islander peoples, particularly through the use of mandatory training programs focused on cultural safety and cultural awareness (McGough et al., 2018). These programs are the most consistent response from mental health services across Australia to the recognition that their level of competency in

providing services to Aboriginal and Torres Strait Islander service users is problematic (O'Brien, Boddy, & Hardy, 2007). In this research, mental health nurses did not identify a clear link between mandatory training and service change. It has been recommended that health professions reflect on their practice and their attitudes and to work collectively to effect systemic change to create culturally safe service environments for Aboriginal and Torres Strait Islander peoples (Durey, Thompson, & Wood, 2012). However, while mandatory training programs would seem to promote individual reflection, there was no evidence found of it developing collective approaches that effected systemic change in mental health services.

If mental health services are serious about providing appropriate services to Aboriginal and Torres Strait Islander peoples, the research findings highlight the need to address the dominance of biomedical approaches to care and treatment in mental health services. Appropriate approaches to mental health service provision for Aboriginal and Torres Strait Islander people are available to guide this reform (Commonwealth of Australia, 2004; Dudgeon, Milroy & Walker (Eds), 2014; Commonwealth of Australia, 2017). At a local level, there is a need for active engagement with Indigenous communities, including the ongoing review of mental health services by community members. Mental health services need to engage in meaningful dialogue with communities about what approaches to care and treatment would best meet community needs. Such engagement should focus on whether valid understandings of Indigenous culture is shaping service provision, moving mental health services away from Western-centric approaches that reflect the dominant hegemony of the biomedical paradigm.

The Australian Government has identified that we are currently in a 'period of rapid reform in Indigenous health' (Commonwealth of Australia, 2017, p. 1). In relation to government policy, there has been a persistent focus on improving mental health services and focusing on social and emotional wellbeing for nearly 20 years (Zubrick et al., 2014). These policies have also

been guided by the need to address the continuing impacts of colonisation on Aboriginal and Torres Strait Islander peoples (Zubrick et al., 2014). Despite these efforts, the provision of mental health services for Aboriginal and Torres Strait Islander peoples have continued to be identified as inadequate and inappropriate (Dudgeon et al, 2014; Commonwealth of Australia, 2017). Contrasting my first experience of this area of practice in 2004 with the circumstances of mental health nursing practice described by nurses during fieldwork twelve years later, the processes of reform would appear to be making slow progress and having limited impact on how mental health services are provided to Aboriginal and Torres Strait Islander peoples. There is a failure in regards the diffusion of policy interventions into clinical environments to improve mental health services for Aboriginal and Torres Strait Islander peoples.

Most recently, the Australian Government's National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (Commonwealth of Australia, 2017) did not identify mental health nurses in its target audience. This is despite the prevalence of mental health nurses in services and the amount of contact they have with Aboriginal and Torres Strait Islander peoples in practice. Based on the findings of this research, a failure to target mental health nursing in relation to the care model for Aboriginal and Torres Strait Islander peoples will only perpetuate the failure of two decades of policy reform to produce mental health services that are appropriate and culturally secure for Aboriginal and Torres Strait Islander peoples.

10.5 Research limitations and future research

Ethnography is a highly interpretative approach to research (Denzin 1997). Much of what is encountered in fieldwork is interpreted by the ethnographer and it cannot be claimed to be

objectively described (Clifford & Marcus 1986). In their interpretative function, the ethnographer then uses this data, contextualised within its socio-cultural milieu, to undertake further interpretations about their fieldwork more broadly (Geertz 1973). Appreciating the *crisis of representation* discussed with Chapter 2, I am aware this thesis is something that I have created. It cannot make claims of being data that is 'objectively' reported. These are not truths. My interpretations of the data are influenced by my positionality- including my cultural background, my professional knowledge, my theoretical influences- all of which impact on this research and the interpretative schema I have applied during the research process (Madison 2011), This has required me to remain reflexive throughout this study in order to attend to how my positionality has affected this research and its writings.

This research is an ethnographic study of non-Indigenous mental health nurses practice with Aboriginal and Torres Strait Islander peoples. Again, this research presents a relatively small number of voices in a multivocal story, with many perspectives and beliefs. The research has not been an attempt to privilege the voices of non-Indigenous nurses at the expense of others but has focused on establishing a depth of analysis in one group amongst many. This has limited the breadth of the study from engaging other key stakeholders such as service users, Indigenous communities and other occupational groups. To address this limitation, further research is needed to analyse the beliefs of other stakeholders in public mental health services.

The study, as it has developed, has been informed by my own professional/personal background. Although I have discussed this study with Aboriginal and Torres Strait Islander people, from clinical backgrounds and non-clinical backgrounds, the study has not been guided by Aboriginal and Torres Strait Islander people in its design or analysis. It is the study emanating from an Irish nurse who has lived in Australia for 14 years and who has worked with non-Indigenous nurses in designing this study and analysis. To address this limitation, future research is needed on the practices of mental health nursing undertaken by Aboriginal

and Torres Strait Islander researchers. Although the multi-sited approach allowed this ethnographic study to go beyond the traditional single site of study, it still provided a limited insight into practice in this area. Further research is warranted on practice with Aboriginal and Torres Strait Islander peoples. Other methodologies would provide additional knowledge to support Indigenous led practice improvement.

10.6 Concluding statement

After decades of criticism related to the appropriateness of public mental health services, there is a glaring need for mental health nurses to partner with Aboriginal and Torres Strait Islander peoples to find out what works to improve the social and emotional wellbeing of Indigenous service users regarding nursing care. Given the high incidence of social and emotional wellbeing problems and mental ill-health, and the elevated levels of need for public mental health services within Indigenous communities, this should be done urgently to ensure mental health nursing care that is both clinically and culturally appropriate. As the most numerous professional group in public mental health services and taking into account the nature of their role working with Aboriginal and Torres Strait Islander people, their families and communities, mental health nurses are fundamental to ensuring rapid and sustainable reform.

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Appendix A: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Dear Participant,

My name is Luke Molloy. I am a Registered Nurse employed by the University of Tasmania. I am currently enrolled in a PhD Program at The University of Tasmania. As part of this course, it is necessary to complete a research project.

This research study will explore mental health nursing as it relates to Aboriginal and Torres Strait Islander Peoples. The title of the study is 'An Ethnographic study examining Mental Health Nursing and its practice with Aboriginal and Torres Strait Islander people'

The aim of this research is to examine the culture of mental health nursing as it relates to the care of Aboriginal and Torres Strait Islander people.

I am inviting you to participate in this study. As a mental health nurse, you can provide expert experience in regards to the research topic. If you agree to involvement in this study, I would like to conduct an interview to gain an insight into your opinions on the area of mental health nursing as it relates to Aboriginal and Torres Strait Islander peoples.

Interviews will be approximately 1 hour in length and will be held at the University of Tasmania, Campus in Darlinghurst or at an agreed location that is convenient to you. I will be audiotaping the interview for future analysis. No incentives will be given to study participants.

Prior to the interview, I will ask you to sign a consent form. You may withdraw from the study at any time, during or after the interview. I will request that you create an alias prior to interview commencement. Information collected during the interview will remain confidential. Data collected will be stored securely at the University's School of Health Sciences for a seven year period. Only my supervisors and I will have access to data collected.

The University of Tasmania Human Research Ethics Committee have approved this research study and no risks have been identified.

Professor Kim Walker is my primary supervisor for this project. If you have any queries regarding the research, please contact me directly through email at Luke.Molloy@utas.edu.au or phone (02) or Professor Walker by phone on (02) or email at Kim.Walker@svha.org

I thank you for your consideration.

Yours sincerely,

Luke Molloy.

If you are a participant in a research project that has ethics approval from UTas HREC, and you would like to make a complaint about the conduct of the research, you should call the Executive Officer on the HREC (Tasmania) Network on +61 3 6226 6254 or email Human.Ethics@utas.edu.au. The Executive Officer will then follow up your concerns with the Chair of the committee and the Chief Investigator of the project.

Appendix B: Informed Consent Form

UNIVERSITY of TASMANIA

An Ethnographic study examining Mental Health Nursing and its practice with Aboriginal and Torres Strait Islander people

Informed Consent Form

- I have read and understood the Information Sheet about this project and any questions I had have been answered to my satisfaction.
- I am aware that interviews conducted with Luke Molloy will be tape-recorded for analysis
- I understand that I may withdraw from participating in the project at any time without prejudice
- I understand that all information gathered by the researcher will be treated as strictly confidential.
- I understand that prior to the commencement of the interview, I will provide an alias to ensure that the risk of participant identification is minimised.
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.
- I understand that once signed and returned, this consent form will be retained by the researcher.

Participant's Signature		Date	

Researcher's Signature		Date	

Researcher's Full Name: Luke Molloy

This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 6254 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H14330.

Appendix C: Interview recruitment email

Calling all Mental Health RNs!
I am currently undertaking my Doctor of Philosophy through the University of Tasmania. I have chosen to explore mental health nursing and the care of Aboriginal and Torres Strait Islander people.
I would like to interview you to gain an understanding of your thoughts on mental health nursing practice and the care of Aboriginal and Torres Strait Islander people. This will be approximately 1 hour in length and will be held at the University of Tasmania, Campus in Darlinghurst or at an agreed location that is convenient to you.
Attached to this email is an information and consent form. Please read through the information sheet and if you have any questions at all regarding this research project, please do not hesitate to ask me.
If you would like to participate, please email me at Luke.Molloy@utas.edu.au or phone me on (02)
All information obtained will remain confidential. I appreciate your time and assistance.
Thank you,
Luke Molloy

Appendix D: Interview Guide

An important consideration in formulating the interviewing questions was that there was an opportunity for the participant to express their ideas and perspectives and that the researcher is open to unanticipated information from which new discoveries may arise. For this reason a semi-structured style of interview has been chosen. Only five guiding questions will be used in each interview to ensure that a consistent approach is utilised with all participants.

1. When I use the phrase 'Mental health nursing care and Aboriginal and Torres Strait Islander People', what meaning does this have for you?

2. What has been your experiences been in practice of caring for Aboriginal and Torres Strait Islander People?

3. What values underpin your practice when you are caring for a person who is an Indigenous Australian?

4. Do you have any thoughts about the care practices that mental health nurses have developed for the care of Aboriginal and Torres Strait Islander people in Australia?

5. What is your opinion of the criticism directed towards the appropriateness of care and treatment that Aboriginal and Torres Strait Islander people receive in public mental health services?

Between these questions I will speak only in relation to the nature of the responses from the participants. Some further questions may be required to seek clarification, some may be needed to draw out detail or examine complexities in the participant's answers.

Appendix E: Recruitment Poster

UNIVERSITY *of* TASMANIA

RESEARCH PROJECT

An Ethnographic study examining Mental Health Nursing and its practice with Aboriginal and Torres Strait Islander people.

If you are working as a Mental Health Nurse in St. Vincent's Hospital, you are invited to share your thoughts on mental health nursing as it relates to Aboriginal and Torres Strait Islander peoples.

Participation in the interviews is voluntary.
All information will remain confidential.

Ethics Approval has been provided by the University of Tasmania and St. Vincent's Hospital Human Ethics Committees

If you are interested, please feel free to contact Luke Molloy, through email (Luke.Molloy@utas.edu.au) or 02 .

Appendix F: Rise of the zombie institution, the failure of mental health nursing leadership, and mental health nursing as a zombie category manuscript

This paper was written as a consequence of conversations between Richard Lakeman and I around the current circumstances of mental health nursing in Australia. Richard is the primary author and led its formalisation and development.

This article has been removed for copyright or proprietary reasons.

Lakeman, R., Molloy, L., 2018. Rise of the zombie institution, the failure of mental health nursing leadership, and mental health nursing as a zombie category, International journal of mental health nursing, 27(3), 1009-1014

Appendix G: List of open codes developed.

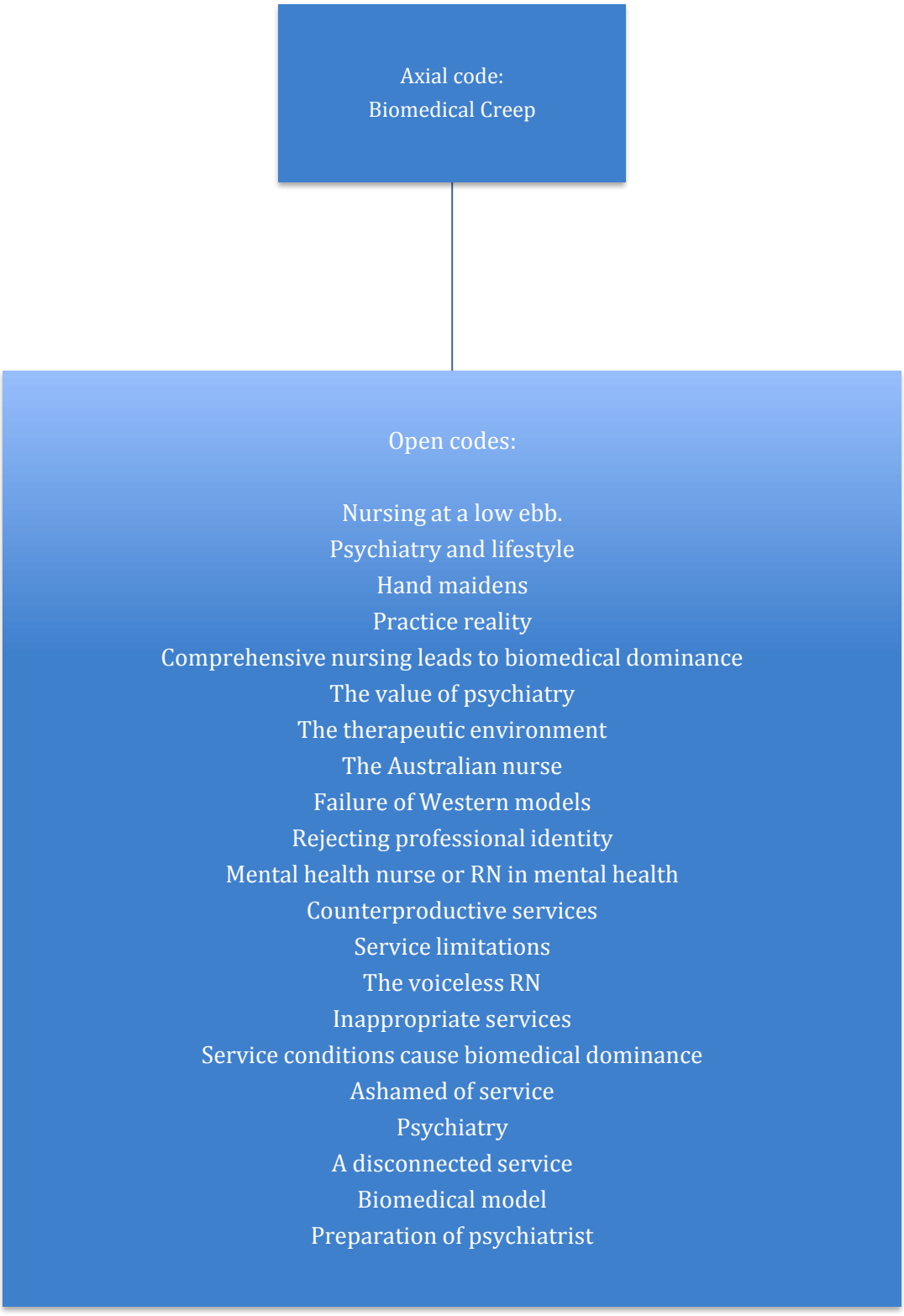
Counterproductive services
We lock people up
Service limitations
Forgotten partners
The band aid approach to service provision
The voiceless RN
Service failure
Same issues for all mental health patients
Broken parts of the system
Service issues
Inpatient attitudes
The service pressure cooker
Reflections on service change
Service actualities
Inappropriate services
Health care mercenaries
Service insights
A culture of different sites
Service conditions cause biomedical dominance
A useful service
A disconnected service
Ashamed of service
Social control
The community
Aboriginal people as practice guides
Outsourcing care
Gender roles
Fear of the Indigenous patient
The Other as an average person
Reasons for illness
Aboriginality as a barrier to mental health nursing
Staying away
Interactions with Indigenous services
Racism
Not culture
No trust
Paradoxes
More impaired
Lack of difference
Psychiatry
Different world
Challenging stereotypes
Wellbeing paradox
Not like our life
Magical
Fear

Non-Indigenous Indigenous experts
Practice experiences
Approaches to practice
Biomedical model
Importance of face to face experiences
Preparation
Working pretty good
Practice experience
Insecurity in approaches
Importance of partnerships
Achievements at ward level
ED as access point
Working with a community focus
Importance of Aboriginal and Torres Strait Islander nurses
White
A specialist practice
Preparing mental health nursing
Cultural safety
Ways forward
Positive practice
Seminal experiences
The guilt
Developed knowledge
The Other
Expertise
Respecting the difference
The old days
Preparation of psychiatrist
Talking for the Other
Australian silence
Culture or illness?
We are not culturally safe
Confusion in practice
Importance of listening
The role of experience
A bit careful and cautious
The importance of time
The importance of relationships
Staffing impacts
Funding impacts
Treating everyone the same
Positive discrimination
Us and them
Lack of resources
Blocking progress
We are getting better
Mental health nurse or RN in mental health
Building practice base
Broader issues
On the defence

Community engagement
Policy practice gap
Professional identity
Professional culture
Where does mental health nursing fit?
The outsider
Time as a key issue to care
Abandoning Western perspectives
Failure of Western models
Imagining an evidence base
Stereotypes
The churn
How we are perceived
An oppressive force
Racism in nursing
The Australian nurse
Aboriginal looking
Success
The Other impacting on role function
Aboriginal workforce
Lip service
Personal philosophies
The importance of location
Care as damage
Experiencing the Others exclusion
Rejecting professional identity
The therapeutic environment
Abusive services
The value of psychiatry
Perceptions from the outside world
The hopeless situation
Stigma
Nursing values
Lack of a tool kit
The other side
We traumatise
It's all about relationships
They trust me
Social control
It's a white problem
Student resistance
Hidden history
Policy
The past
Lost in practice
Comprehensive nursing leads to biomedical dominance
Band aid
Limitations of mental health nursing
Not racist but what's the point attitude attitudes
The challenges

A slow journey to change
Awareness and overgeneralising
Practice reality
Lack of specialisation
Culture is serious business
Everyone is criticising us
What does cultural safety look like?
A different kettle of fish
Same same but different
The family
Aware of the simple things
Sitting in the dirt
The challenge of the ward
Psychiatry and lifestyle
Biomedical creep
Aboriginal stigma
Hand maidens
Nursing at a low ebb
'Being with' learning

Appendix H: Example of axial coding



Appendix I: Ethics

Social Science Ethics Officer
Private Bag 01 Hobart
Tasmania 7001 Australia
Tel: (03) 6226 2763
Fax: (03) 6226 7148
Katherine.Shaw@utas.edu.au

HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

27 October 2014

Professor Kim Walker
St Vincent's Private Hospital
406 Victoria Street
Darlinghurst NSW

Student Researcher: Luke Molloy

Sent via email

Dear Professor Walker

Re: FULL ETHICS APPLICATION APPROVAL
Ethics Ref: **H0014330 - An ethnographic study examining Mental Health Nursing and its practice with Aboriginal and Torres Strait Islander people**

We are pleased to advise that the Tasmania Social Sciences Human Research Ethics Committee approved the above project on 27 October 2014.

This approval constitutes ethical clearance by the Tasmania Social Sciences Human Research Ethics Committee. The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approval of other bodies or authorities is required. It is recommended that the proposed research should not commence until you have satisfied these requirements.

Please note that this approval is for four years and is conditional upon receipt of an annual Progress Report. Ethics approval for this project will lapse if a Progress Report is not submitted.

The following conditions apply to this approval. Failure to abide by these conditions may result in suspension or discontinuation of approval.

1. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval, to ensure the project is conducted as approved by the Ethics Committee, and to notify the Committee if any investigators are added to, or cease involvement with, the project.

2. Complaints: If any complaints are received or ethical issues arise during the course of the project, investigators should advise the Executive Officer of the Ethics Committee on 03 6226 7479 or human.ethics@utas.edu.au.

3. Incidents or adverse effects: Investigators should notify the Ethics Committee immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

4. Amendments to Project: Modifications to the project must not proceed until approval is obtained from the Ethics Committee. Please submit an Amendment Form (available on our website) to notify the Ethics Committee of the proposed modifications.

5. Annual Report: Continued approval for this project is dependent on the submission of a Progress Report by the anniversary date of your approval. You will be sent a courtesy reminder closer to this date. **Failure to submit a Progress Report will mean that ethics approval for this project will lapse.**

6. Final Report: A Final Report and a copy of any published material arising from the project, either in full or abstract, must be provided at the end of the project.

Yours sincerely

Katherine Shaw
Executive Officer
Tasmania Social Sciences HREC

Queensland
Government

Research Governance Office
Cairns and Hinterland
Hospital and Health Service

Telephone: (07) 4226 5512
Ref: *08.10: JHJ:mg*
Email: RGO_Cairns@health.qld.gov.au

Mr Luke Molloy
University of Tasmania
1 Leichhardt Street,
Darlinghurst NSW 2010

Dear Mr Molloy

HREC reference number: HREC/15/QCH/40 - 971
SSA reference number: SSA/15/QCH/110 - 971
Project title: An ethnographic study examining Mental Health Nursing and its practice with Aboriginal and Torres Strait Islander people
Protocol number: N/A

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the following site(s):

Cairns and Hinterland Hospital and Health Service: Cairns Hospital

The following conditions apply to this research proposal. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval.

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project are to be submitted to the HREC for review. A copy of the HREC approval/rejection letter must be submitted to the RGO;
2. Proposed amendments to the research protocol or conduct of the research which only affects the ongoing site acceptability of the project, are to be submitted to the Research Governance Officer;
3. Proposed amendments to the research protocol or conduct of the research which may affect both the going ethical acceptability of the project and the site acceptability of the project are to be submitted firstly to the HREC for review and then to the research governance officer after a HREC decision is made.

Yours sincerely

Julie Hartley-Jones CBE 29.10.15
Chief Executive
Cairns and Hinterland Hospital and Health Service

William McCormack Place
Level 7
5 B Sheridan Street
PO Box 902
CAIRNS QLD 4870

St Vincent's Hospital

A facility of St Vincent's
& Mater Health Sydney

St Vincent's Hospital Sydney Ltd
ABN 77 054 038 872
390 Victoria Street
Darlinghurst NSW 2010
Australia

T + 61 2 8382 1111
F + 61 2 9332 4142
www.stvincents.com.au

19 November 2015

Prof Kim Walker
Professor of Healthcare Improvement
St Vincent's Private Hospital
Research Centre
203 Barcom Road
Darlinghurst NSW 2043

Dear Kim,

SVH File Number: 15/267
Project Title: An ethnographic study examining Mental Health Nursing and its practice with Aboriginal and Torres Strait Islander people.
HREC Reference Number: LNR/15/SVH/408

Thank you for submitting the above project for ethical and scientific review

Based on the information you have provided and in accordance with the NHMRC National Statement 2007 and NSW Health Policy Directive PD2010_055 'Ethical and Scientific Review of Human Research in NSW Public Health Organisations', this project has been assessed as low/negligible risk and is therefore exempt from full HREC review.

This HREC has been accredited by NSW Ministry of Health as a Lead HREC under the model for single ethical and scientific review and Certified by the NHMRC under the National model for Harmonisation of Multicentre Ethical Review (HoMER). This lead HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. No HREC members with a conflict of interest were present for review of this project.

I am pleased to advise that the HREC Executive at a meeting on **17 November 2015** has granted ethical and scientific approval of the above **single centre** project.

You are reminded that this letter constitutes *ETHICAL* and *SCIENTIFIC* approval only. You must not commence this research project at a site until a completed Site Specific Assessment Form and associated documentation have been submitted to the site Research Governance Officer and Authorised. A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

The project is approved to be conducted at **St Vincent's Hospital, Sydney**

If a new site(s) is to be added please inform the HREC in writing and submit a Site Specific Assessment Form (SSA) to the Research Governance Officer at the new site.

The following documents have been approved:

- Protocol, Version 1, dated 14 September 2015
- Poster for Recruitment, Version 1.0, dated 15 September
- Participant Information Sheet and Consent Form, Version 4.0, dated 30 November 2015
- Interview Schedule, Version 2.0, dated 16 June 2015

The Low and Negligible Risk Research Form (LNRF) reviewed by the HREC was LNRF **AU/6/8291214**

Please note the following conditions of approval:

- HREC approval is valid for **5 years** from the date of the HREC Executive Committee meeting and expires on **17 November 2020**. The Co-ordinating Investigator is required to notify the HREC 6 months prior to this date if the project is expected to extend beyond the original approval date at which time the HREC will advise of the requirements for ongoing approval of the study.
- The Co-ordinating Investigator will provide an Annual Progress Report beginning in **November 2016**, to the HREC as well as a Final Study Report at the completion of the project in the specified format.
- The Co-ordinating Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project and any complaints made by participants regarding the conduct of the project.
- Proposed changes to the research protocol, conduct of the research, or length of approval will be provided to the HREC Executive for review, in the specified format.
- The HREC Executive will be notified, giving reasons, if the project is discontinued before the expected date of completion.
- Investigators holding an academic appointment (including conjoint appointments) and students undertaking a project as part of a University course may also be required to notify the relevant University HREC of the project. Investigators and students are advised to contact the relevant HREC to seek advice regarding their requirements.

Please note that only an electronic copy of this letter will be provided, if you require the original signed letter please contact the Research Office and we will be happy to provide this.

Should you have any queries about your project please contact the Research Office, Ph: (02) 8382-2075 or by E-mail: SVHS.Research@svha.org.au. The HREC Terms of Reference, Standard Operating Procedures, *National Statement on Ethical Conduct in Human Research* (2007) and the *CPMP/ICH Note for Guidance on Good Clinical Practice* and standard forms are available on the Research Office web-site to be found at: https://svhs.org.au/home/research-education/research-office

Please quote **SVH File Number: 15/267** in all correspondence.

The HREC wishes you every success in your research.

Yours sincerely,

[redacted]
HREC Executive Officer
St Vincent's Hospital Research Office
Level 6, de Lacy Building

cc: Luke Molloy
TRIM REF: D/2015/63870

APPENDIX J: Permissions

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1 PAYMENT 2 REVIEW 3 CONFIRMATION

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Order Date: 09/04/2018

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Payment Information

Luke Molloy
lmolloy@uow.edu.au
+61 (4)
Payment Method: n/a

Order Details

Nurse researcher

Order detail ID:	71528963
Order License Id:	4421750716267
ISSN:	1351-5578
Publication Type:	Journal
Volume:	
Issue:	
Start page:	
Publisher:	R C N PUBLISHING CO.
Author/Editor:	Nursing Standard

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Permission type: Republish or display content
Type of use: Thesis/Dissertation

Requestor type	Author of requested content
Format	Print, Electronic
Portion	chapter/article
The requesting person/organization	Luke Molloy
Title or numeric reference of the portion(s)	Molloy, L., Walker, K., & Lakeman, R.. (2017). Shared worlds: multi-sited ethnography and nursing research. Nurse Researcher, 24(4), 22-26.
Title of the article or chapter the portion is from	Molloy, L., Walker, K., & Lakeman, R.. (2017). Shared worlds: multi-sited ethnography and nursing research. Nurse Researcher, 24(4), 22-26.
Editor of portion(s)	N/A
Author of portion(s)	Luke Molloy
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